Ministry of
Health Services

2003/04
Annual Service Plan Report

BRITISH
COLUMBIA

National Library of Canada Cataloguing in Publication Data
British Columbia. Ministry of Health Services.
Annual Service Plan Report. — 2002/03 —

Annual.
Report year ends Mar. 31.
Continues: British Columbia. Ministry of Health Services. Performance plan. ISSN 1703-4590.
ISSN 1708-1017 = Service plan — British Columbia. Ministry of Health Services.

1. British Columbia. Ministry of Health Services — Periodicals. 2. Medical policy — British Columbia — Periodicals. 3. Health services administration — British Columbia — Periodicals. I. Title. II. Title: Ministry of Health Services Annual Service Plan Report.

RA185.B7B74 353.6'09711'05 C2003-960149-8

For more information on the British Columbia
Ministry of Health Services
visit our Website at
www.gov.bc.ca/healthservices/

Published by the Ministry of Health Services

Table of Contents

Accountability Statements 5

Message from the Ministers 7

Year-at-a-Glance Highlights 9

Ministry Role and Services 13

Performance Reporting 20

Report on Resources 79

Appendix 1: Acts Under the Administration of the Minister of Health Services 87

Appendix 2: Professions Regulated by the Minister of Health Services 89

Appendix 3: *New Era* Commitments 90

Accountability Statement

The 2003/04 Ministry of Health Services Annual Service Plan Report was prepared under my direction and in accordance with the *Budget Transparency and Accountability Act*. This report compares the actual results to the expected results identified in the ministry's 2003/04 Service Plan. I am accountable for the ministry's results and the basis on which they have been reported.

Honourable Colin Hansen
Minister of Health Services

June 23, 2004

Minister of State for Mental Health Statement of Results

Under the *Balanced Budget and Ministerial Accountability Act*, the Minister of State for Mental Health was accountable for the following results. Information on actual results will not be available until December 2004, at which time they will be made public.

- Increasing the proportion of mental health patients (aged 15 to 64) who receive community or physician follow-up within 30 days of being discharged from hospital.
- Increasing the proportion of mental health services (community, physician and acute care) received by mental health clients (aged 15 to 64) that are obtained in their own health authority.

For preliminary results see pages 32 and 35.

Minister of State for Intermediate, Long Term and Home Care Statement of Results

Under the *Balanced Budget and Ministerial Accountability Act* the Minister of State for Intermediate, Long Term and Home Care, was accountable for the following results. Information on actual results will not be available until December 2004, at which time they will be made public.

- Increasing by two per cent the percentage of home and community care clients with high care needs living in their own home rather than in a facility.
- Decreasing by five per cent the percentage of days spent by patients in hospitals after the need for hospital care has ended.

For preliminary results see pages 25 and 29.

BRITISH
COLUMBIA

Ministry of Health Services

It is my privilege to present the 2003/04 Annual Service Plan Report for the Ministry of Health Services. This report describes our progress in maintaining and protecting public health, providing patients the care they need, and building a dependable, sustainable health care system.

British Columbia's health system faces many challenges. These include the need for flexible care options for a changing and aging population; rising demand for new and expensive drugs, equipment and technology; increasing incidence of chronic diseases; and unsustainable funding increases. The result is we have to redesign our health system to ensure it provides high quality health outcomes in a manner that is sustainable into the future.

We have taken significant steps to address these challenges and to improve the delivery of services, however there is more to be done. As we move forward with redesigning the health system, I appreciate the dedication and contributions of government's partners in health care: BC's health authorities, health professionals and caregivers. Our shared efforts are making a real, positive difference to the health and well being of this province's citizens, families and communities.

Our continued success depends on our individual and collective efforts to first and foremost keep people healthy by preventing illness and disease, and then, when people do become ill, to provide them with appropriate and timely care. As we redesign the system, it is essential we use leading-edge research and evidence-based decision-making to ensure investments in the health system produce excellence in health outcomes and care. BC is a leader in many areas of health care reform, and we are already well on our way to re-engineering and redesigning the system to ensure citizens of today and tomorrow are healthy and well cared for.

The 2003/04 Annual Service Plan Report highlights the progress we have made as well as the challenges and goals still before us. Together, we can achieve our vision of a healthier population with a sustainable public health care system that meets the diverse and changing needs of British Columbians.

Colin Hansen

Honourable Colin Hansen
Minister of Health Services

Message from the Minister of State for Mental Health and Addiction Services

As the 2003/04 Annual Service Plan Report shows, British Columbia has made substantial progress in mental health and addiction services over the past three years. During this time, the Ministry of Health Services has worked together with care providers, community leaders, other provincial ministries, individuals and their families to revitalize BC's mental health and addictions system.

Together, these partners have been transforming the mental health and addictions system into one that is recovery-oriented and evidence-based — a health system that best meets the needs of British Columbians. Changes and improvements include bringing together the policy, long-range planning and management of mental health and addiction services. Now, health authorities plan and integrate mental health and addiction services across the province.

An important initiative is the development of a permanent communications infrastructure for mental health literacy in the province. We have brought together provincial mental health and addictions agencies to develop state of the knowledge documents, information materials and self-management toolkits to assist individuals and families to manage their health and make healthy choices. This work is parallel to our ongoing work with the Mental Health Evaluation and Community Consultation Unit at UBC, and with the Centre for Addiction Research BC located at the University of Victoria.

We are also making connections to improve the continuum of care from childhood to adulthood. Last year, the provincial government launched Canada's first comprehensive child and youth mental health plan through the Ministry of Children and Family Development. This five-year plan focuses on early identification of at-risk children and on providing appropriate treatment and support services to youth who are affected by mental illness. Already under development is the child, adolescent and women's mental health centre, expected to open early in 2006.

Our partnerships and efforts continue to help increase awareness and create a health system that both acknowledges mental illness and addictions and promotes mental health to improve care and wellness for individuals, families and communities throughout the province.

Susan Brice

Honourable Susan Brice
Minister of State for Mental Health and Addiction Services

Year-at-a-Glance Highlights

Over the past year, the Ministry of Health Services has made significant progress in some key goals and priorities for BC's health care system. These include protecting public health, ensuring patients get timely access to appropriate quality care, and planning for a dependable and sustainable health system. We are making progress in every one of these areas.

Maintaining the status quo in BC's health system has not been an option. Over the past decade, health care costs have been rapidly rising and consuming an ever increasing portion of the government's overall budget. With limited resources and greater demands, this trend is not sustainable. Therefore, fundamental changes have to be made.

Making innovative changes and improvements, especially those that challenge long-standing or traditional approaches or methods is not easy. However, new health research and leading journals show us there are new, creative and efficient ways of improving health care and health outcomes for British Columbians. This means making some difficult decisions, and we are now well on our way to re-engineering and redesigning the health system to meet British Columbians' diverse needs in a sustainable way. British Columbians — patients, care providers and the public — are beginning to see positive results from the long-term planning and hard work being undertaken across the health sector.

Significant achievements in 2003/04 include:

Protecting Public Health

- New immunization programs were launched, including vaccinations for preventing meningococcal, pneumococcal and whooping cough diseases, aimed at covering school-age children and people at high risk.
- New measures governing drinking water help to protect the health and safety of British Columbians. The amended *Drinking Water Protection Act* and regulations came into force on May 16, 2003. The changes establish a comprehensive and coordinated framework for protecting the province's drinking water from source to tap.
- BC agencies effectively managed and coordinated BC's public health response to Severe Acute Respiratory Syndrome (SARS). $2.6 million was invested for research to accelerate the development of a vaccine against SARS.
- Prevention measures relating to West Nile Virus are well underway. The ministry is working with the Provincial Health Officer, the BC Centre for Disease Control, health authorities, and municipal governments to plan appropriate mosquito control measures.
- The BC Centre for Disease Control and the Michael Smith Genome Sciences Centre are placing British Columbia at the forefront of Canada and the world in health research. The ministry has contributed $15 million to Genome BC, one of five not-for-profit genome centres established to coordinate genomics research in Canada. Genome BC research includes developing ways to track how cells transform into malignancies and become

cancerous. This is significant for diagnosing early stage cancers, including lung, breast, prostate, gastro-intestinal, oral, lymphoid and myeloid tumors.

- The government has provided over $24 million to the Michael Smith Foundation for Health Research for new programs in BC which continue to develop, attract and retain outstanding health scientists and researchers. This funding supports research in priority areas such as health care re-engineering and innovation.
- Emergency and disaster support services are being strengthened in communities across BC with the addition of 10 new medical support ambulances.
- A new assisted living registrar helps protect the health and safety of seniors and people with disabilities who make assisted living residences their home.

Providing High Quality, Patient-Centred Care

- Supported by an investment of $74 million over four years, BC's health authorities have been implementing a range of initiatives to support more comprehensive, coordinated and accessible primary health care services. Initiatives include: networks linking family physician practices; community health centres; shared care arrangements providing family practices with specialist consultation and expertise; nurse managed care in regions with limited access to physicians; and chronic disease management.
- BC NurseLine, which provides British Columbians with 24-hour health information and advice in over 130 languages, has been expanded to include a pharmacist service that answers medication-related calls from 5pm to 9am daily. Since April 2001, BC NurseLine has helped over 560,000 callers and use of this health resource continues to increase.
- The ministry is helping doctors better manage chronic diseases and improve patient care. Initiatives have focused on improved care for people living with diabetes, congestive heart failure, depression, asthma, arthritis, kidney disease, chronic pulmonary obstructive disease and hypertension. The ministry has also launched the Chronic Disease Management Toolkit for Practitioners, using secure web-based technology to provide tools and information to support optimal chronic disease management.
- New primary health care organizations provide a one-stop source for primary health services by a team of health professionals to best meet patients' needs. The Agassiz Community Health Centre opened in October 2003 with a team of four family physicians, a primary care nurse, and other health professionals.
- A new $29-million expansion of Nanaimo Regional General Hospital to improve access to patient care, maternal programs and surgical services on Central Vancouver Island is under construction.
- New investments of $10 million increased patient access to surgical services, including general surgery, neurosurgery, thoracic and orthopedic surgery in the Interior Health Region.
- The government provided $2 million to the Rick Hansen Man in Motion Foundation to support its leading team of researchers and clinicians plan and research in the spinal cord injury field.

- Renal services have been expanded beyond the major urban centres with new kidney dialysis services in Kelowna, Penticton, Creston, Terrace and Nanaimo.
- A new BC Autism Assessment Network has reduced wait times for diagnosis of autism in children under six years of age.
- New investments in telehealth technology allow patients to access the specialist care they need from BC Children's, Sunny Hill and BC Women's Hospitals without having to travel from their own communities.
- Over 700 new, affordable assisted living units for seniors and people with disabilities have been completed. Assisted living residences provide a care setting and support for those who do not require 24-hour nursing care, yet need help with daily tasks such as housekeeping, bathing and managing medications.
- Waiting time for residential care has been reduced from an average of over one year to an average of close to two months.
- Residents of the northwest who have a mental illness will soon receive care closer to home when the new $2.5 million Seven Sisters Residential Adult Mental Health Facility opens in 2004. The new facility is part of government's commitment to replace outdated institutional care with modern, home-like environments, and to create networks of care and revitalize mental health services across the province.
- A new seven-bed mental health facility opened in Vernon, and more facilities are under development across the province. New facilities in Kelowna, Smithers and Fort St. John will be completed in 2004.
- Over $21 million was invested in new medical equipment, including: new CT scanners for Lion's Gate and Richmond Hospitals; three gamma cameras and a new catheter lab at Royal Columbian Hospital; a new angiographic system at Royal Jubilee Hospital; new radiotrophic tomographic units for Hazelton, Chetwynd, Burns Lake and Vanderhoof; a new mammography unit in White Rock; new anaesthetic machines for Smithers and Vanderhoof; and new patient beds and lifting devices across the Interior Health Region.
- The Jim Pattison Pavilion Tower at Vancouver General Hospital opened in May 2003. The 19-storey inpatient tower houses 459 new beds, along with modern equipment and care facilities.

Managing for Sustainability

- In May 2003, the Fair PharmaCare Program came into effect to modernize the provincial drug insurance plan and make it more equitable, ensuring financial assistance with prescription drug costs and other medical supplies is available to BC families who need it most.
- Government committed $2.5 million to Action Schools! BC. This initiative is designed to help children become more physically active and to provide low-cost resources to educators, parents and community groups to complement current programs. Partners include the Ministry of Community, Aboriginal and Women's Services, the Ministry of Education, the University of British Columbia and the 2010 LegaciesNow Society.

- BC will be graduating more doctors in the future through its expansion of the University of British Columbia Medical School. The expansion will almost double the number of medical school spaces. For the first time, the school will provide training through satellite centres in Victoria and Prince George. The ministry has also established 32 new postgraduate positions — the beginning of the stepped expansion to the postgraduate (residency) medical education program. Over the next decade residencies will expand to keep pace with the MD undergraduate program expansion.
- To ensure the system has enough nurses, government has committed $59 million to BC's Nursing Strategy since 2001. This includes the creation of approximately 2,000 new education spaces for nurses in BC. Government has also funded more than 700 nurses to take refresher, qualifying or English-as-a-second-language courses to allow non-practicing Canadian graduates or internationally educated, non-practicing BC residents to be eligible to return to nursing.
- To ensure maximum value for health care dollars, a public-private partnership is being pursued to build a new Abbotsford Hospital and Cancer Centre to replace the aging Matsqui-Sumas-Abbotsford (MSA) Hospital. The new hospital and cancer centre will provide enhanced programs and services to meet the needs of Fraser Valley residents for the next 30 years.
- The government is working with a private sector partner to develop a new service delivery model for the operations of the Medical Services Plan (MSP) and BC PharmaCare. The goal of this initiative is to improve customer service, promote efficiency, inject capital investment into the existing technology infrastructure and ensure the security and privacy of sensitive health information. The new model will improve client services and access to MSP functions, such as enrolment, family status changes, birth registrations and applications for premium assistance.
- Technology investments are improving efficiency and patient care. For example, the Fraser Health Authority's innovative Picture Archiving and Communication System links diagnostic imaging equipment, such as MRI equipment and ultrasounds, to a network of computers. This network increases efficiency and allows doctors to view results throughout the health authority.

Ministry Role and Services

Ministry Overview

The Ministry of Health Services provides funding, support and leadership to BC's health authorities and other partners in delivering quality, appropriate and timely health services. The ministry primarily acts as steward of the system by: developing legislation, policy and standards; setting immediate and long-term direction through strategic planning; and monitoring, evaluating and reporting on system performance. The ministry's partners deliver the vast majority of health services to the public, although the ministry still delivers a small percentage of services through the BC Ambulance Service, Vital Statistics Agency, PharmaCare Program and Medical Services Plan.

Since 2001, the ministry has been leading a significant redesign and reform effort to build an accountable and sustainable publicly funded health system that meets the needs of British Columbians.

One aspect of reform, the consolidation of health authorities from 52 to six, introduced a simpler, more accountable governance model for health service delivery. Now, five regional health authorities oversee the majority of health services in communities, such as emergency and acute care, while a provincial authority manages specialized health services, such as cancer care.

Within these roles, the ministry and health authorities have strengthened partnerships to build a more effective and sustainable system. To improve accountability and quality of care, performance agreements between the ministry and health authorities were introduced in 2002/03. The agreements establish objectives and performance measures for BC's health authorities and health system.

The partnership model is crucial to the success of health system reforms. As reform efforts are primarily focused on improving services, the ministry's success is largely reliant on productive working relationships with those who deliver services. The majority of the performance measures and targets in the ministry's service plan are related to services delivered by health authorities and other partners (e.g., physicians). In 2003/04, the ministry worked with health authorities to continue to improve the performance agreements, and explored opportunities to strengthen relationships with other service providers.

Ministry Vision, Mission and Values

Vision

A health system that ensures high quality public health care services that meet patients' needs where they live and when they need them.

Mission

To guide and enhance the province's health services to ensure British Columbians are supported in their efforts to maintain and improve their health.

The top priorities are renewing public health care while providing high quality public health care services that meet patients' most essential needs.

Values

A set of beliefs, consistent with the principles of the *Canada Health Act*, defines our organizational behaviour:

- **Patient and consumer focus** which respects the needs and diversity of all British Columbians.
- **Equity** of access and in the quality of services delivered by government.
- **Access** for all to required health services.
- **Effectiveness** of delivery and treatment leading to appropriate outcomes.
- **Efficiency,** providing lowest cost consistent with quality services.
- **Appropriateness,** providing the right service at the right time in the right place.
- **Safety** in the delivery of health services to minimize the risks to the health and safety of British Columbians.

Ministry Operating Context

British Columbians are generally healthy and have a quality health system they can depend on. Among other positive measures, British Columbia has the highest life expectancy, lowest smoking rate, and highest rate of physical activity of any province in the country. The Provincial Health Officer's 2002 Annual Report, released in 2003/04, confirms the population's healthy state while acknowledging some areas where improvements could be made. Tracking social, economic, environmental, and health conditions across the province, the report gives a broad snapshot of the health system and the health of the population. Of the 91 indicators used, 41 showed improvement, 31 remained relatively unchanged, five had no trend or recent data and only 14 had a negative trend. (The report can be found at http://www.healthservices.gov.bc.ca/pho/.)

Challenges and Risks

While health outcomes are generally good, the sustainability of the health system continues to face a number of financial and service delivery challenges.

Cost Drivers and Demand Pressures

Rising costs and demands put pressure on the health budget, including:

- Rising use and cost of pharmaceuticals; higher service expectations; and rapid and expensive technological innovations.
- Increasing pressure from both health care providers and the public for government to fund new technologies, pharmaceuticals and clinical interventions regardless of established effectiveness or value for money.
- Increasing need to update or expand health care facilities and equipment.
- Increasing rate of obesity and incidence of chronic disease.
- New diseases, which result in new tests, drugs and treatments.
- New treatments for previously untreatable conditions.
- Increasing prevalence of public health emergencies such as SARS, Avian flu, and West Nile Virus.

Demographic Trends

Population growth and demographic shifts also put pressure on the health system. Health services tend to be used at higher rates as the population ages.

- BC's population increased by 31,600 persons in 2003, and is expected to increase by 38,800 persons in 2004, 42,400 in 2005 and 45,800 in 2006. In 2000 BC's population was 4,039,200. By 2006 it is forecast to be 4,273,600, an increase of six per cent.
- BC's population is aging. Relative to 2000, by 2010, there will be 26 per cent more people over 65, 30 per cent more over 75, and 63 per cent more over 85. The median age in BC is forecast to reach 40 by 2006. This is up from 35.4 years in 1995.
- Life expectancy is increasing. By 2010, the median age at death will be 80.7 years.
- The health system's workforce is also aging, and attracting and retaining high quality staff in the health sector is difficult at a time of global shortages in health care professionals.

Capacity to Manage Risks

Funding for BC's health system has continued to grow. In 2003/04, government's health budget was $10.7 billion, up from an initial budget of $9.3 billion in 2001/02. That total represents approximately 42 per cent of all government spending, the highest proportion ever and in stark contrast to just 10 years ago when the health budget was $6.47 billion and consumed 33 per cent of total government spending. However, even with these significant funding increases the system is hard pressed to keep up with demand.

The health system's capacity to respond to increased demand is limited not just by resources, but also by structure. Designed at a time when most care was delivered in a hospital setting, the system's original configuration no longer meets today's needs and often provides care in more expensive and less effective ways than necessary. Consequently, a major strategic focus has been to redesign the system to respond effectively to the health needs of today's and tomorrow's citizens. The majority of our 2003/04 service plan objectives relate to this redesign, which includes: emphasizing health promotion and disease prevention activities to keep people healthy and out of the health care system; providing the appropriate level of care in the appropriate setting — for example, moving away from sole dependence on residential care for the frail elderly and disabled, to an appropriate mix of home care, assisted living and residential care; and providing tailored care based on best practices for chronic disease sufferers.

To realize these reforms and build a system that will remain sustainable in the face of the many challenges, the ministry has strengthened the relationship with its health system partners and refocused its role on planning, monitoring and evaluation. In 2003/04, the ministry used the following management approaches to meet its service plan objectives and build a sustainable health system:

- Continued the move to evidence-based decision-making and the application of best practices.
- Making the public aware of how unhealthy lifestyle choices can affect health.
- Streamlining to focus on core businesses and priority issues.
- Developing and implementing standards of care and accountability to improve the delivery of health services and patient outcomes.
- Using formal planning and projection tools to forecast the services that will be required to meet the health needs of British Columbians.
- Fostering cooperative working relations with health system partners.
- Building relationships with other provincial ministries to facilitate the coordination of services.
- Directing, supporting, monitoring and reporting on system performance and accountability.
- Involving experienced staff and external experts with extensive knowledge of the issues facing the system.

Ministry Structure and Core Business Areas

The ministry and its health care partners have distinct roles and responsibilities in creating a responsive, patient-centred health system. Our service providers — health authorities and care providers — deliver the majority of health services to their communities and patients. The ministry oversees the health system and provides stewardship and corporate management to support health service delivery across the province.

Specifically, there are three core business areas for the ministry and the health system:

- Services Delivered by Partners;
- Services Delivered by Ministry; and
- Stewardship and Corporate Management.

Services Delivered by Partners

The provincial and regional health authorities, agencies and care providers are key partners who deliver the majority of health services to British Columbians. These partners have a range of responsibilities, including identifying patients' needs, planning health resources, allocating health care funding, and managing service delivery in regions of the province. Services delivered span beginning to end-of-life care, disease prevention to health promotion, and primary to acute care.

Health authorities oversee the delivery of most of these health services, such as providing public health programs and acute care services at hospitals. Doctors and other care providers are vital partners in ensuring that patients get the care they need.

Services Delivered by Partners accounts for the vast majority of health expenditures ($10.1 billion budget in 2003/04) and is the primary focus of the system redesign efforts detailed in the ministry's service plan and this report.

Services Delivered by Ministry

Health Benefit Operations

Health Benefit Operations provides the administrative services for BC's PharmaCare Program and Medical Services Plan. PharmaCare is the province's drug insurance program, which assists British Columbians with paying for eligible prescription drugs and medical supplies. The Medical Services Plan covers medically required services provided by physicians and certain supplementary health care practitioners.

Emergency Health Services

The ministry delivers emergency health services through the Emergency Health Services Commission and the British Columbia Ambulance Service.

Vital Statistics Agency

The Vital Statistics Agency is responsible for documenting important events for BC citizens such as births, marriages and deaths.

Stewardship and Corporate Management

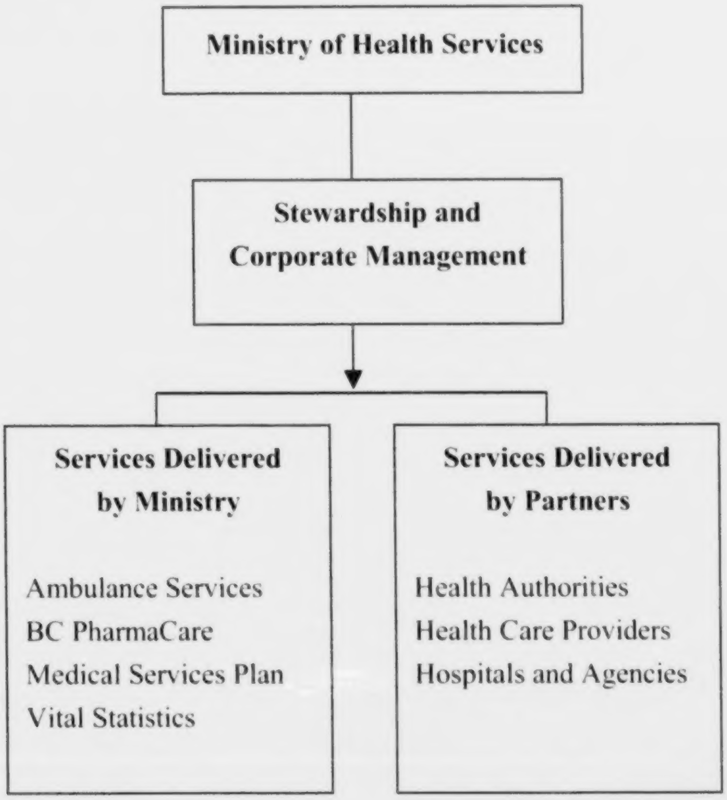
As stewards of the health system, the ministry provides leadership and support to health authorities and other partners. The ministry manages BC's health system through service plans and annual service plan reports, and legislation and policy. It also establishes service expectations and performance agreements with health authorities.

The ministry supports the system by using planning and projection tools to forecast services required to meet the diverse and changing health care needs of British Columbians. To improve quality of care, the ministry also works with its partners to research and develop provincial standards, guidelines and best practices for service delivery. In addition, the Provincial Health Officer monitors and reports annually on the health of British Columbians, and makes recommendations to the public and provincial and federal governments on improving health and wellness.

Further, the ministry monitors and evaluates health system performance by collecting and analyzing health system data. This enables the ministry and its partners to take evidence-based, corrective action and informs future development of service plans and performance agreements.

Corporate Management includes managing ministry budgets, human resources and business requirements. To fulfill the stewardship role, it is essential for the ministry to manage its corporate functions efficiently and effectively.

Core Business Areas for the Ministry of Health Services


Ministry of Health Services
Stewardship and Corporate Management
Services Delivered by Ministry
Ambulance Services
BC PharmaCare
Medical Services Plan
Vital Statistics
Services Delivered by Partners
Health Authorities
Health Care Providers
Hospitals and Agencies

Strategic Shifts and Significant Changes in Policy Direction

In 2003/04, the Ministry of Health Services underwent organizational change to reflect its amalgamation with the Ministry of Health Planning. In January 2004, the ministry assumed the functions of health planning. Both ministries had previously worked in close partnership, and therefore the impact on programs and services has been minimal. Core functions of the former Ministry of Health Planning, including health system planning, public health protection, population health reporting, and legislation and policy development continue under the Ministry of Health Services. Objectives, strategies and performance measures from the 2003/04 – 2005/06 Ministry of Health Planning Service Plan have been incorporated into the Ministry of Health Services' plan and reporting on progress is included in this report.

Another significant organizational change was the establishment of the Knowledge Management and Technology Division. The division was created in November 2003 to enable the consolidation and transformation of information management systems and technology, including the Vital Statistics Agency, into one portfolio, and ensure a coordinated approach in this critical area. This reflects the ministry's commitment to evidence-based decision-making and its desire for better use of health data and information.

The Ministry of Health Services did not undertake any significant shifts in policy or strategic direction during the 2003/04 fiscal year. The ministry identified five key objectives and related priority strategies in last year's and in the current 2004/05 – 2006/07 Service Plan. Four of the objectives relate to services delivered by partners, while one is for services delivered by the ministry. These objectives continue to guide the ministry's and health authorities' planning and operational activities — and are the focus of health system redesign efforts.

Update on *New Era* Commitments

In June 2001, the Ministry of Health Services began work on implementing 44 *New Era* commitments for the health system. Significant progress has been made with 34 commitments having been either completed or incorporated as an ongoing part of the ministry's operations. Work on each of the remaining 10 is well underway. For a complete listing of the commitments and their status, please see Appendix 3 on page 90.

Performance Reporting

The provincial government has made a strong commitment to transparent performance reporting in the health sector. The ministry is working with health authorities and agencies, such as the Canadian Institute for Health Information, to ensure required data are available and are of acceptable quality to fulfill this commitment.

A challenge to timely reporting is the unavailability of data. Reporting on performance measures at the provincial level is a complex process. For example, measures that report on hospital performance have a lag between the moment an event occurs and the time when data generated from that event is collected, checked and assembled in a usable format. Generally, the movement of hospital data through the system takes three months; however, because the measures in this report are at a provincial level, the ministry must wait for all hospitals to submit data. Because some data can take up to six months to report, it is impossible to have complete data for all measures by the Annual Service Plan Report publication date.

In 2003/04, the ministry and health authorities began a review of all performance measures in the ministry's annual service plan and the health authorities' performance agreements to test and improve them, using nine criteria such as reliability, relevance and comparability. This review is expected to result in the refinement of several measures and the creation of new measures to assist with decision-making and evaluating progress towards achieving the ministry's strategic objectives. Improved measures will be added to future service plans and performance agreements when ready.

As mentioned, some measures in this report do not have complete data for the 2003/04 fiscal year. Where partial data is available for the fiscal year, it is reported; where no data is available for 2003/04, the most recent year's data is reported. Performance reporting shows results over several years to illustrate trends and provide context for recent results. Given the size and scope of the health system, viewing results over time gives a clearer, broader indication of performance in a given area.

Overview of Ministry Goals

To renew public health and improve health care services for British Columbians, the ministry has embarked on a wide-ranging strategy of health system reform. Reform efforts are designed to meet government's three long-term goals for BC's health care system:

Goal 1: High Quality Patient Care

Patients receive appropriate, effective, quality care at the right time in the right setting. Health services are planned, managed and delivered in concert with patient needs.

Goal 2: Improved Health and Wellness for British Columbians

British Columbians are supported in their pursuit of better health through health protection and promotion and disease prevention activities.

Goal 3: A Sustainable, Affordable Public Health System

The public health system is affordable, efficient and accountable, with governors, providers and patients taking responsibility for the provision and use of services.

Report on Results

The ministry's 2003/04 – 2005/06 Service Plan contained a number of objectives and strategies designed to move the health system toward reaching these goals. This section reports on those objectives and strategies, as well as actual results of performance compared to the targets set out in the 2003/04 – 2005/06 Service Plan.

Core Business: Services Delivered by Partners

The core business Services Delivered by Partners comprises the majority of health services delivered to the public. These services span beginning to end-of-life care, health promotion to disease prevention, and primary to acute care. There are four objectives under this core business, as outlined in the ministry's service plan. To achieve these objectives, the ministry works closely with those health care partners that deliver services directly to the public.

Goal 1: High Quality Patient Care

Objective 1: Provide care at the appropriate level in the appropriate setting by shifting the mix of acute and institutional care to more home and community care.

Our hospitals, community services and health care professionals must be used in the most effective and efficient way possible to lead to the best patient outcomes. A problem at one level of the system has ramifications for others. For example, a lack of adequate services in the community could lead to the following gridlock in acute care: "Verna" is waiting in an acute care medical bed for appropriate services in the community to enable her discharge from hospital. "Fred" is on a stretcher in the emergency room waiting for Verna to move so a bed will become free to allow him to be admitted upstairs. "Ethel" is in the ambulance and diverted to another hospital because Fred and others are backlogged in the emergency room. "Jennifer's" elective surgery is delayed because of the shortage of acute care beds. This objective's aim is to avoid this scenario by bolstering services in the community.

BC's health authorities are the ministry's key partners in changing the structure of the health system. Health authorities have been given the managerial scope to implement large-scale structural changes to how health care services are delivered. These redesign efforts, which were begun in 2001 and are still underway in communities throughout BC, are shifting the mix of services and health care providers to ensure care is delivered at the most appropriate level and setting. The goal is to create an integrated network of services, which links primary care, diagnostics, home and community care and acute care. In an integrated system the patient will move more easily between various settings and providers, and will not be left waiting at one level for services to be provided at another.

Priority Strategy 1: Hospital Admissions Prevention through Increased Community Care Options: Prevent unnecessary hospitalizations by providing patients with better access to family physicians, specialists, other providers and services in the community.

Many patients who are admitted for treatment to a hospital could receive appropriate care in a less intensive setting. The ministry, health authorities and care providers are working together to improve access to family physicians and other community resources so people can get the care they need, without unnecessary hospitalization.

Enhancing primary care is the key to achieving this strategy. Primary care is a patient's first and most frequent point of contact with the health system and supports individuals and families to make the best decisions for their health. Patients access primary care when they visit their doctor, medical clinic, or public health unit. Between 2002 and 2006, BC has allocated $74 million from the Health Canada Primary Care Transition Fund to make improvements in primary care. Most of this funding has supported health authorities' initiatives in providing more comprehensive, accessible primary health care services. Regional initiatives include:

- primary health care organizations;
- networks linking family practices;
- community health centres;
- shared care arrangements providing family practices with specialist consultation and expertise;
- nurse managed care in regions with limited access to physicians; and
- chronic disease management.

To provide 24-hour health resources to all British Columbians province-wide, the ministry continues to expand the BC HealthGuide Program, giving BC residents access to medically approved health information and advice 24 hours a day, seven days a week. This program consists of a 400-page BC HealthGuide Handbook, a companion First Nations Health Handbook, a comprehensive website at http://www.bchealthguide.org, the BC NurseLine and pharmacist services, and the BC HealthFiles. More information on the BC NurseLine can be found under Performance Measure 2.

PS – Performance Measure 1: Rates of admission for conditions that could be managed outside hospital (conditions classified as "may not require hospitalization").

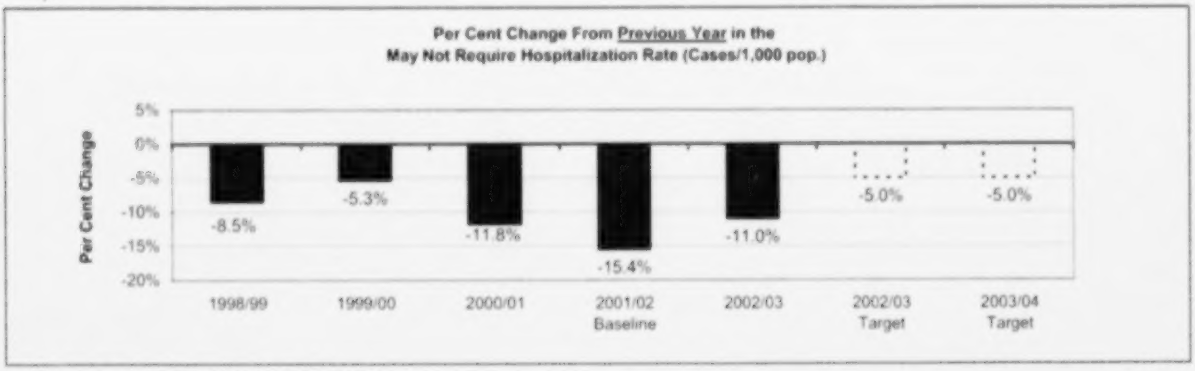
This rate helps identify opportunities to more efficiently manage resources by focusing expensive, specialized hospital care on those who truly need it, and treating less acute cases in a more cost-effective and clinically appropriate manner. Specifically, when patients are admitted to hospital they are classified into case groups based on their diagnosis. One of these groups is "may not require hospitalization" (MNRH). Asthma and hernia are among the conditions that fall under this category — conditions which can be treated without admission to hospital.

This performance measure helps the ministry assess success of the first part of priority strategy one, to "prevent unnecessary hospitalizations".

Results:

2003/04 Target	2003/04 Preliminary	Status*
5% decrease over prior year	N/A	Pending

	Fiscal Year						
	1998/99	1999/00	2000/01	2001/02 Baseline	2002/2003	2002/03 Target	2003/04 Target
MNRH rate (cases/1,000 pop.)	8.3	7.8	6.9	5.9	5.2	—	—
Per cent change from previous year	–8.5%	–5.3%	–11.8%	–15.4%	–11.0%	–5.0%	–5.0%
Per cent change from baseline	N/A	N/A	N/A	N/A	11.0%	—	—



* 2003/04 — data not available.

Data Source: Discharge Abstract Database, Oct 16, 2003, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services (ref # 2003_541); P.E.O.P.L.E. 27, BC Stats.

Analysis: Data for 2003/04 is not available at this time. Data for 2002/03 is available and shown here. The data show a declining trend over several years in cases identified as "may not require hospitalization." This indicates improvements in providing appropriate care that meets patients' needs. Specifically, hospital services are being used for those patients who require acute or specialized care, while other patients who do not require hospitalization are receiving appropriate treatment in other settings.

It is important to note that a target rate of zero MNRH cases is unrealistic. In some instances, a patient's clinical situation and/or other patient safety issues that may be taken into account by the admitting physician may well justify admission to hospital, even though the diagnostic coding indicates MNRH. Generally, a lower rate of MNRH is more likely to reflect efficient use of beds than a higher rate.

PS – Performance Measure 2: BC NurseLine use rates.

British Columbians can call the 24-hour BC NurseLine toll-free and speak with registered nurses specially trained to provide confidential health information and advice on the telephone. The nurses help callers understand and manage health concerns, get health information on home treatment and other care options, and get advice on when to see a health professional. BC NurseLine answers questions about various health topics, tests and medical procedures, and provides information on other community resources. BC NurseLine also provides a pharmacist service from 5pm to 9am daily to answer medication-related calls.

Results:

2003/04 Target	2003/04 Actual	Status
35% increase in NurseLine use (from 2001/02 baseline)	141.6% increase	Exceeded target
25% increase in calls referred from physicians offices/ walk-in clinics (from 2001/02 baseline)	2064.5% increase	Exceeded target

		Fiscal Year			
		2001/02	2002/03	2003/04	2004/05*
Call Volume	**Target**	Baseline	25.0%	35.0%	60.0%
Call Volume		103,471	172,934	250,018	N/A
➔ Per cent change in call volume over baseline		—	67.1%	141.6%	N/A
Calls referred from physicians' offices/walk-in clinics	**Target**	Baseline	15.0%	25.0%	150.0%
Calls referred from physicians' offices/walk-in clinics		335	1,423	7,251	N/A
➔ Per cent change in calls transferred over baseline		—	324.8%	2064.5%	N/A

* The baseline for 2004/05 targets has been shifted from 2001/02 to 2002/03, as call volumes have grown dramatically since 2001.

Data Source: BC NurseLine Call Manager Database, BC HealthGuide Program, Population Health and Wellness, Ministry of Health Services.

Analysis: BC NurseLine has experienced significant growth in call volumes during its first three years of operation. Providing 24/7 access to health services is vital to improving primary health care and building a patient-centred health system in BC. The number of calls BC NurseLine receives helps gauge whether British Columbians are accessing health resources that will reduce demand on hospitals and physicians.

Currently, it is general practice among physicians and walk-in clinics to direct patients to hospital emergency departments after hours. BC NurseLine provides an alternative for obtaining an assessment of symptoms or health concerns, and for getting the appropriate level of care. Since April 2001, when it began, there has been a dramatic increase in the number of callers referred by physician offices and walk-in clinics (part two of the measure). This indicates physicians and patients have been using the BC NurseLine option, thereby reducing demand on emergency and physician services.

In 2003/04, including information on BC NurseLine in public health alerts such as SARS, forest fires and the flu campaign, contributed to the increase in call volumes. The ministry will continue to conduct outreach and educational efforts aimed at increasing awareness of the BC NurseLine by both the public and health professionals.

Priority Strategy 2: Post Acute (hospital care) Alternatives: Provide appropriate community health support to enable timely discharge of patients from hospital once the need for acute medical care has ended.

Patients may remain in hospital longer than necessary for various reasons, including lack of available room in a residential facility or lack of community services to support discharge from hospital. The ministry and health authorities have been working to ensure the right mix of services is available so patients can access appropriate services once the need for hospital care has ended. This will result in better care for patients and better use of health system resources.

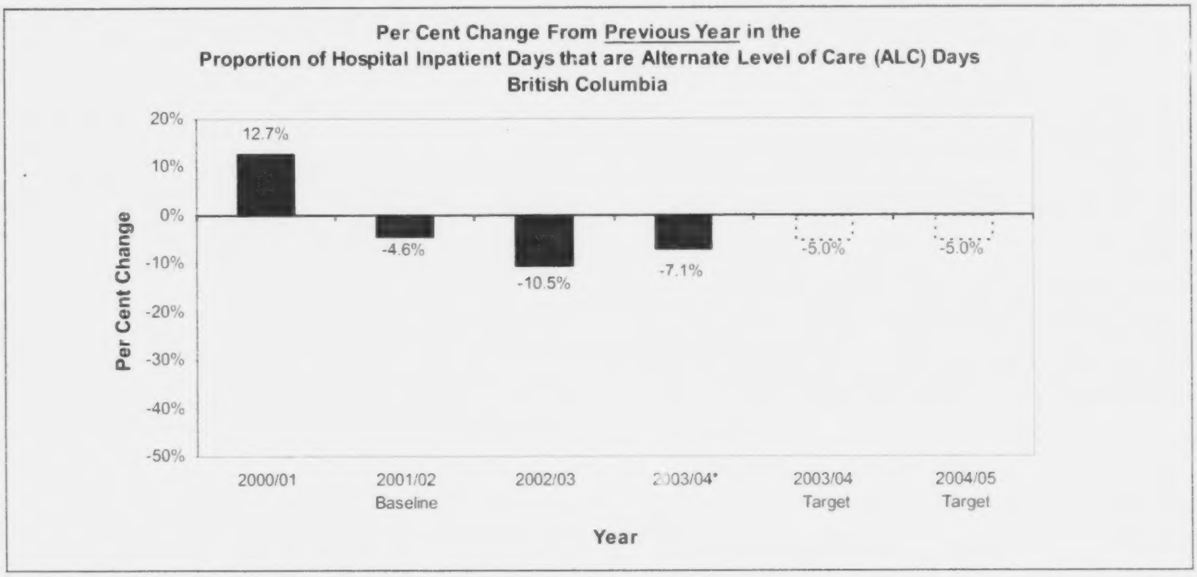
PS – Performance Measure 3: Percentage of days spent by patients in hospitals after the need for hospital care ended measured by alternate level of care days as a percentage of total hospital inpatient days.

This measure indicates whether patients have timely access to appropriate care in the most appropriate setting. The days patients spend in hospital after the need for acute care has ended are called alternate level of care (ALC) days. A reduction in ALC days means more appropriate care is being delivered to patients, resulting in more acute care hospital beds being available for those who need acute care.

Results:

2003/04 Target	2003/04 Preliminary	Status
5% decrease over prior year	7.1% decrease	On track

	Fiscal Year					
	1999/00	2000/01	2001/02	2002/03	2003/04*	2004/05
Annual Target			Baseline	–5.0%	–5.0%	–5.0%
ALC Days	379,930	424,922	388,002	338,607	198,808	N/A
Inpatient Days	2,750,961	2,730,992	2,612,915	2,549,034	1,610,410	N/A
Per cent ALC Days	13.8%	15.6%	14.8%	13.3%	12.3%	N/A
➔ Per cent Change in per cent ALC Days from previous year	N/A	12.7%	–4.6%	–10.5%	–7.1%	N/A



Per Cent Change From Previous Year in the Proportion of Hospital Inpatient Days that are Alternate Level of Care (ALC) Days British Columbia

* 2003/04 — partial year data.

Data Source: Discharge Abstract Database (DAD), March 2004, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services.

Notes: Riverview hospital only started reporting in the DAD as of 2002/03. The change in the number of inpatient days between 2001/02 and 2002/03 is largely due to the inclusion of Riverview patients with a length of stay less than 180 days. The data in this report will vary from previous versions of this report for 2002/03.

Analysis: Based on preliminary data, the target for reducing the number of ALC days will be exceeded in 2003/04. The significant decrease in ALC days indicates more timely discharge of patients from hospital and the availability of more appropriate community health support. Health authorities have focused on better use of acute care hospital resources as a key priority and have implemented specific strategies to reduce ALC days.

Over the last year, health authorities have added new sub-acute, hospice, and convalescent care beds to the continuum of care. Health authorities have also enhanced community supports, which include post-acute care provided by home care nurses, therapists and home support aides. As well, they have increased access to adult day care and assisted living — a relatively new care option that offers housing, hospitality and personal care services. In addition, more appropriate care and timely discharge from hospital have resulted from regional access lists for residential care and the creation of convalescent beds for patients who require a range of health services on a short-term basis before returning home.

Priority Strategy 3: Effective Management of Acute Care Services in Hospitals: Plan for and manage the demand on emergency health services and surgical and procedural services.

While most of the strategies under this objective are focused on providing services outside the hospital, this strategy focuses on ensuring needed hospital services are provided in a timely and high quality manner. Under this strategy, the ministry and all six health authorities have participated in two province-wide projects to improve access to, and effectiveness of, emergency room and surgical services in hospitals across the province.

PS – Performance Measure 5: Waiting times for key services:

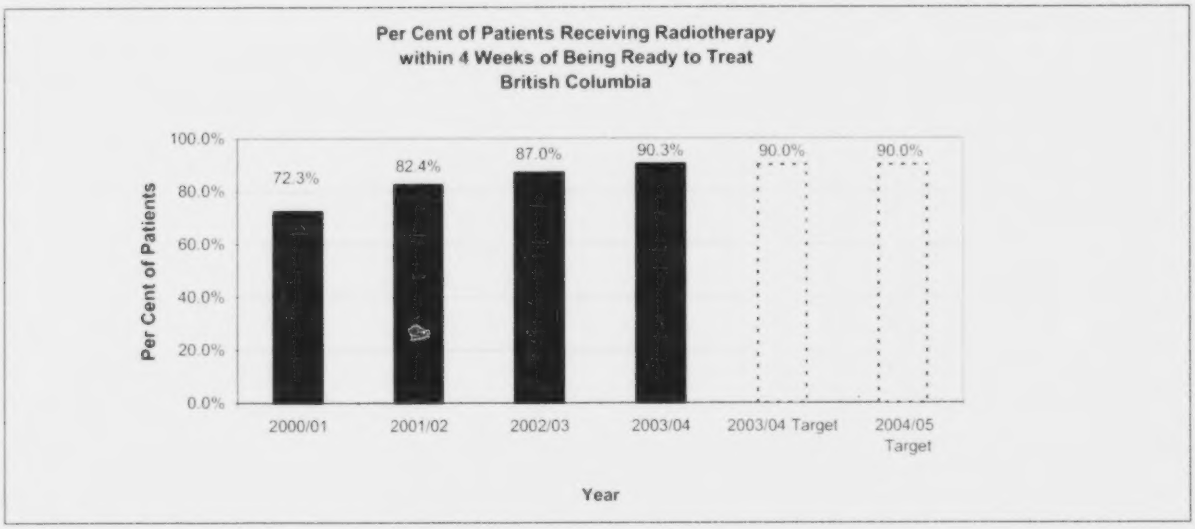
a) Radiotherapy
b) Chemotherapy

Monitoring wait times for these key services helps ensure patients' cancers are treated as early as possible to achieve the best outcomes. This indicator measures the percentage of patients that begin radiotherapy within four weeks of being ready to treat and the percentage of patients who start chemotherapy within two weeks of being ready to treat.

Results:

2003/04 Target	2003/04 Actual	Status
a) 90% of radiotherapy patients begin treatment within 4 weeks of being ready to treat	90.3%	Met target
b) 90% of chemotherapy patients begin treatment within 2 weeks of being ready to treat	90%	Met target

Radiotherapy	Fiscal Year				
	2000/01	2001/02	2002/03	2003/04	2004/05
Annual Target			90.0%	90.0%	90.0%
Per cent patients receiving radiotherapy treatment within 4 weeks	72.3%	82.4%	87.0%	90.3%	N/A



Data Source: Provincial Radiation Therapy Program, BC Cancer Agency.

Analysis: All radiotherapy treatments in BC are provided by the BC Cancer Agency (BCCA). The agency emphasizes the importance of timely access to radiotherapy. Over the past four years, the percentage of patients receiving radiotherapy within four weeks of being ready to treat has increased from 72.3 per cent in 2000/01 to 90.3 per cent in 2003/04. It is encouraging for both patients and the agency that the 90 per cent target has been reached for the first time in 2003/04.

For chemotherapy, the BCCA has a standard in place that patients will receive therapy within 14 calendar days of the physician's order being written. The BCCA has confirmed to the ministry that patients in BCCA centres are being treated within the standard in 90 per cent of cases. (Historically, chemotherapy wait times have not been captured in the BCCA database; however, data to capture wait times for new patients is being implemented in early 2004.)

Overall, British Columbia has excellent cancer outcomes, including some of the best survival rates in Canada for breast and prostate cancer, with 91 per cent of prostate patients and 85 per cent of breast cancer patients alive five years after diagnosis.

PS–Performance Measure 6: Emergency Room Use measure TBD.

A set of guidelines, best practices and performance measures for the management of emergency rooms is being developed as part of the ongoing Provincial Emergency Services Project (PESP) that involves the ministry and each health authority. In 2003/04, the PESP released the Emergency Services Short-term Task Group Progress Report; the report is available at http://www.phsa.ca on the Provincial Health Services Authority website. All health authorities are now working to implement recommendations from this report.

An Emergency Services Long-Term Task Group also began work in 2003 to create a strategic plan for long-term reform and improvement, and ongoing evaluation of the emergency services system. The Task Group has broad practitioner and health authority representation, including community, primary care and chronic disease experts. Provincial performance measures will be developed and adopted in future service plans and/or health authority performance agreements.

Priority Strategy 4: Alternatives to Institutional Care: Help elderly and disabled individuals avoid institutionalization and remain as independent as possible in their own homes and communities by increasing the range of supportive housing environments and community care options while reserving residential institutions for patients with the most complex care needs.

Over the last three years, health authorities have been implementing redesign strategies to shift the balance of care from traditional residential care facilities to home and community options such as assisted living. This new model of care will better meet the needs of clients and their desire for more autonomy as they age. It will also help make the health system more sustainable by focusing resources on providing appropriate care in the appropriate setting, rather than simply admitting the elderly or disabled to facilities designed for complex care.

In 2003/04, health authorities' redesign plans for Home and Community Care were well underway. The full implementation of a new access policy for residential care eliminated long wait lists by ensuring only those people who meet established criteria and require complex care are admitted to a residential care facility. To ensure more efficient use of residential care beds, health authorities have established priority access systems that coordinate the use of beds throughout each region, resulting in faster transitions from acute care to the appropriate care setting.

With regard to community services, the commitment to build 3,500 new affordable assisted living units is underway with over 700 completed. This relatively new care setting offers an option for people who cannot live at home, but do not yet require the 24-hour nursing care and supervision provided in residential care. Another strategy is to provide more direct care services, such as home care nursing, occupational/physical therapy, and home support services for patients in their homes.

PS – Performance Measure 4: Percentage of clients with high care needs living in their own home rather than a facility.

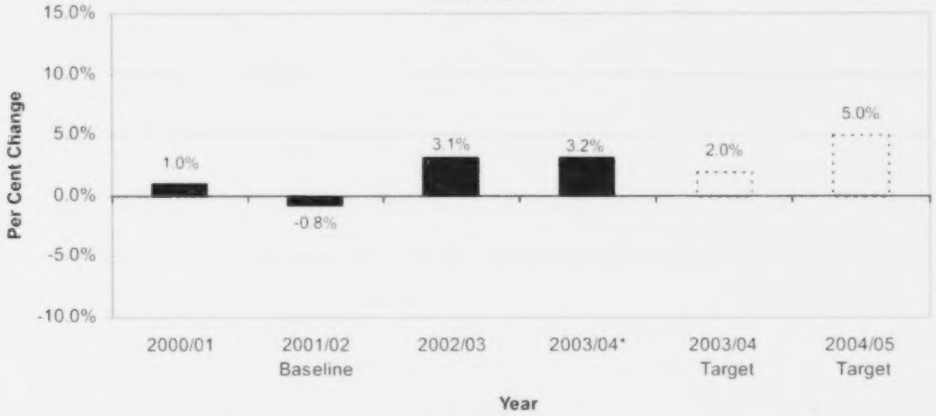
This indicator tracks the percentage of seniors and people with disabilities who have high care needs and receive home support or adult day care services to allow them to remain more independent. Evidence indicates more people can and want to remain at home for as long as possible if they have appropriate support. This improves quality of life and reduces demand for residential care beds.

Results:

2003/04 Target	2003/04 Preliminary	Status
2% increase over prior year	3.2% increase	On track

	Fiscal Year					
	1999/00	2000/01	2001/02	2002/03	2003/04*	2004/05
Annual Target			Baseline	2.0%	2.0%	5.0%
Total Number of high needs clients	42,994	44,193	44,076	43,235	43,323	N/A
Number of clients receiving care at home	18,754	19,466	19,267	19,494	20,157	N/A
Per cent of clients receiving care at home	43.6%	44.0%	43.7%	45.1%	46.5%	
➔ Change in per cent of clients at home from previous year	N/A	1.0%	–0.8%	3.1%	3.2%	

Per Cent Change From the Previous Year in the Proportion of HCC Clients With High Level Care Needs Receiving Care in Their Own Home British Columbia



* 2003/04 — partial year data (to Dec. 31, 2003).

Data Source: CCData Warehouse, April refresh, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services.

Notes: Only clients assessed at Intensive Care 2, Intensive Care 3 or Extended Care are included in the report. Data for clients receiving care at home includes Adult Day Care, Home Support, Community Supports for Independent Living, and Assisted Living authorized by Long-Term Care Case Management or Mental Health.

Analysis: Based on preliminary data, the target will be exceeded for 2003/04. This indicates more clients with high care needs are receiving appropriate home and community-based services, and avoiding institutionalization. Receiving support in their own homes improves quality of life for many clients and results in more efficient use of critical care resources.

In 2003/04, health authorities focused on improving services and expanding care for patients with complex needs. Innovative home support services have been introduced, including cluster care — a more efficient, effective way of delivering support by assigning a home care aide to an apartment building to meet clients' needs throughout the day. Health authorities also expanded adult day care programs to monitor people at risk, keep them engaged in their community, and allow them to remain in their homes for as long as possible. Networks of Excellence for Geriatric Services, including community outreach, were also expanded. Specialized programs for Aboriginal clients and people with brain injuries were also developed to allow clients to remain in the community. Finally, health authorities implemented end-of-life care strategies, including appropriate supports to give people the choice to die in their homes, rather than an institution.

Priority Strategy 5: Build the Foundation for Integrated Care Networks:

a) Connect physicians and other health care professionals to diagnostic services, hospitals, and each other.

b) Provide a continuum of services in each health authority for mental health patients that better integrates primary, secondary, community and tertiary mental health care and is integrated with the larger care networks.

This strategy focuses on integrating and providing care in the most coordinated and seamless manner possible to the benefit of patients and health care providers. The first part of the strategy concerns adapting business processes and using technology to allow care providers, and facilities such as laboratories and hospitals to share information and provide coordinated care. Developing an electronic health record (EHR) system is essential for electronically linking health information to support clinical and management decision-making. British Columbia continues to make good progress in this regard and is seen nationally as one of the leaders in the development of the EHR.

The second part of the strategy focuses on integrating and coordinating mental health and addiction services. In the past, people with mental illness or substance misuse disorders have generally not received the same level of care and respect as people with a physical illness. Mental illness and addictions are treatable, and with appropriate care and support, people can manage their illness better and achieve their full potential. The ministry is working with its health care partners to create networks of care in each health authority that better integrate mental health and addiction services — and coordinate other health services in the region. We are working to provide appropriate care in patients' communities, to minimize their time spent in institutions, and to improve their access to health professionals.

In British Columbia, we are also building capacity for each health authority to deliver new mental health and addiction services. New facilities and services will create more home-like settings and expand the network of care throughout the province, eventually replacing Riverview Hospital. This approach will help improve health outcomes and quality of life for individuals with mental illness and/or addictions.

PS – Performance Measure 7: Improved continuity of care measured by the proportion of persons (aged 15 to 64) hospitalized for a mental health diagnosis who receive community or physician follow-up within 30 days of discharge.

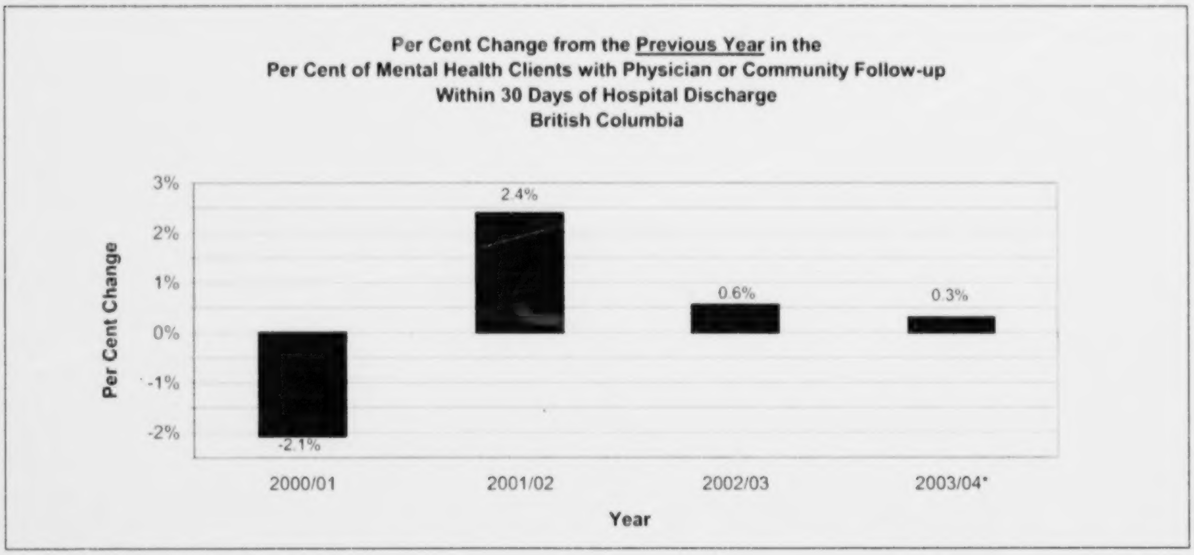
This measures the percentage of persons aged 15-64 who have been hospitalized for a mental health illness and receive at least one follow-up treatment at a community-based Mental Health Centre or with a general practitioner or psychiatrist within 30 days of being discharged from hospital. This measure links to priority strategy 5b as a high rate of community or physician follow-up indicates well-coordinated, accessible continuity of care for people with a mental health diagnosis.

Results:

2003/04 Target	2003/04 Preliminary	Status
Increase over prior year	0.3% increase	On track

	Fiscal Year					
	1999/00	2000/01	2001/02	2002/03	2003/04*	2004/05
Annual Target		Baseline		3.0%	increase	increase
Per cent Clients Followed-up	71.7%	70.2%	71.9%	72.3%	72.5%	N/A
➔ Change in per cent followed-up from previous year	N/A	−2.1%	2.4%	0.6%	0.3%	N/A
Change in per cent followed-up from baseline (2000/01)	N/A	N/A	N/A	3.0%	3.3%	N/A

* 2003/04 — partial year data.


Per Cent Change from the Previous Year in the Per Cent of Mental Health Clients with Physician or Community Follow-up Within 30 Days of Hospital Discharge British Columbia

* 2003/04 — partial year data.

Data Source: 1999/00-2002/03 Mental Health Research Database (MHR): Dec 1, 2003.

Discharge Abstract Database (DAD), acute separations to March 31, 2003; Client Patient Information Management System (CPIM), care episodes to October 27, 2003; Medical Services Plan fee-for-service database (MSP), payments to November 3, 2003.

2003/04 Mental Health Research Database (MHR): March 2004 Refresh.

Discharge Abstract Database (DAD), acute separations to January 29, 2004; Client Patient Information Management System (CPIM), care episodes to March 8, 2004; Medical Services Plan fee-for-service database (MSP), payments to February 18, 2004; Mental Health Minimum Reporting Requirements (MRR), March 12, 2004.

Notes: This analysis may be impacted by possible ICD10CCI-to-ICD9CCP translation issues in source hospitalization data.

2002/03 — Data may understate the number of out-of-province hospitalizations of BC residents as data from Alberta are incomplete for 2002/03. There is an estimated 800 (25 per cent) Alberta inpatient cases missing.

Analysis: Over 70 per cent of mental health clients discharged from acute care hospitals receive timely follow-up by either a physician or a mental health centre. Since 2000/01, there has been a gradual increase in this follow-up rate, and based on partial year data the rate is projected to increase modestly in 2003/04.

Health authorities are continuing to build networks of services to ensure mental health patients receive appropriate care. While increasing follow-up rates remains a priority, there are several factors why some patients may not receive follow-up within 30 days. For some patients there may not be a clinical need, while others may refuse follow-up treatment or fail to show up for scheduled appointments.

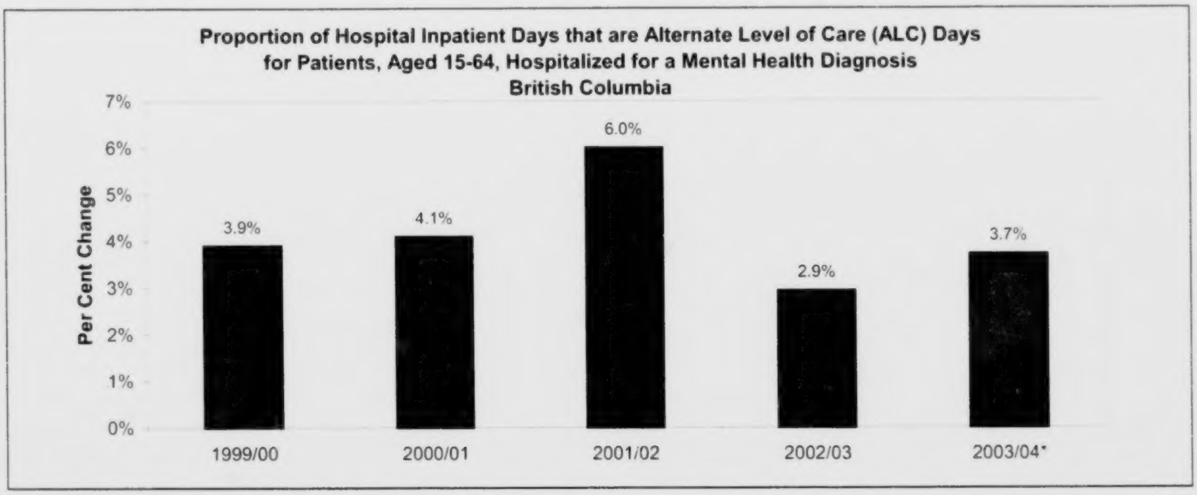
PS – Performance Measure 8: Improved availability of community services measured by percentage of days spent by mental health patients (aged 15 to 64) in hospital after the need for hospital care ends.

This measure indicates whether individuals with mental illness have access to timely, appropriate care in the most appropriate setting. Please note this measure is the same as the previous ALC measure (page 25), but focuses on people who are hospitalized for a mental health diagnosis. Reducing the number of days that patients spend in hospital after their need for acute care has ended indicates that appropriate services are available in the community.

Results:

2003/04 Target	2003/04 Preliminary	Status
2% reduction over prior year	27% increase	Not on track

	Fiscal Year					
	1999/00	2000/01	2001/02	2002/03	2003/04*	2004/05
Annual Target			Baseline	0.0%	–2.0%	–2.0%
ALC Days	8,897	9,509	13,924	7,267	6,334	N/A
Inpatient Days	228,452	232,687	232,366	248,514	170,601	N/A
Per cent ALC Days	3.9%	4.1%	6.0%	2.9%	3.7%	N/A
➔ Per cent Change in per cent ALC Days from previous year	N/A	4.9%	46.6%	–51.2%	27.0%	N/A


Proportion of Hospital Inpatient Days that are Alternate Level of Care (ALC) Days for Patients, Aged 15-64, Hospitalized for a Mental Health Diagnosis British Columbia

* 2003/04 — partial year data.

Data Source: Discharge Abstract Database (DAD), March 2004, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services.

Analysis: Preliminary data suggest the target of further reductions in the ALC rate will not be met in 2003/04. Health authorities have been implementing strategies to improve discharge planning and utilization management, bolster community services, and strengthen networks of care. These strategies should keep the ALC rate low and help ensure mental health patients are treated in the most appropriate settings.

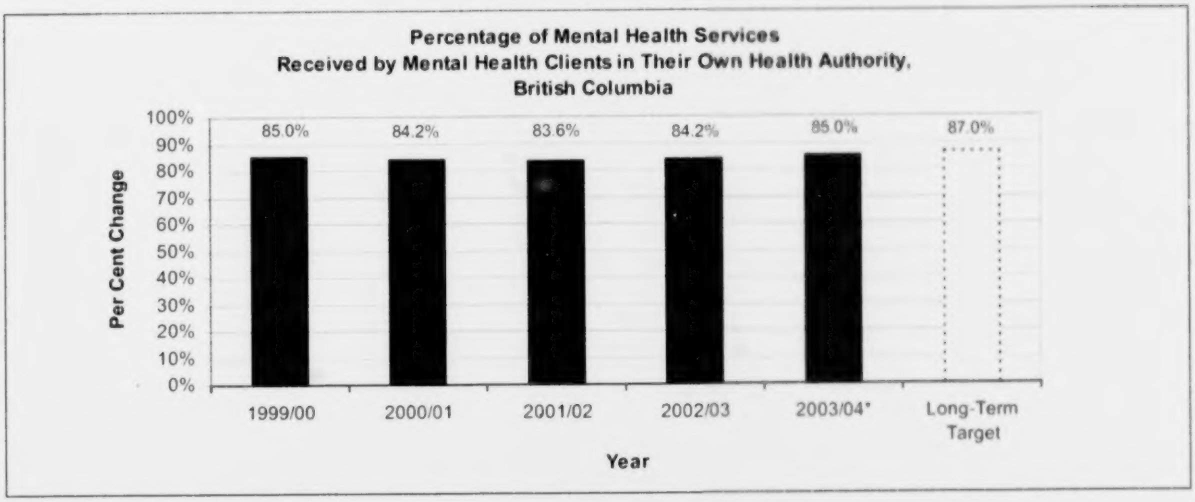
PS – Performance Measure 9: Proportion of mental health services, such as community, physician and acute care, received by mental health clients ages 15 to 64 that are obtained in their own health authority.

This indicator measures the range of services mental health clients receive in their own communities or regional health authorities. This performance measure indicates our progress in improving access and availability of mental health care and community services for individuals in their regions.

Results:

2003/04 Target	2003/04 Preliminary	Status
Increase towards long-term target of 87%	Increase to 85%	On track

	Fiscal Year						
	1999/00	2000/01	2001/02	2002/03	2003/04*	2004/05	Long-term Target
Annual Target			Baseline	Increase	Increase	Increase	
Percentage of Services Received in Client's Own HA							
All Mental Health Services	85.0%	84.2%	83.6%	84.2%	85.0%		87.0%



* 2003/04 — partial year data.

Data Source: Mental Health Research Database (MHR): March 2004 Update.

Discharge Abstract Database (DAD), acute separations to January 29, 2004.

Client Patient Information Management System (CPIM), care episodes to March 8, 2004.

Medical Services Plan fee-for-service database (MSP), payments to February 18, 2004.

Mental Health Minimum Reporting Requirements (MRR), March 12, 2004.

Analysis: Partial data for 2003/04 indicate we are making progress toward our long-term target of 87 per cent of clients receiving services in their own communities or regions. A project to decentralize specialized mental health services will further enhance the ability of health authorities to offer services in their own regions. In the past, seriously mentally ill patients have been treated at Riverview Hospital in the Lower Mainland. Now, as part of a redesign of mental health services, capacity is created in each region to treat those patients. The clinical teams at Riverview Hospital are working closely with those based in the geographic health authorities to improve access to specialized mental health services around the province. This will enable many Riverview Hospital patients to transfer to new, more home-like facilities closer to their home communities, and continue to receive the same high quality care and support.

Core Business: Services Delivered by Partners *(continued)*

Goal 1: High Quality Patient Care *(continued)*

Objective 2: Provide tailored care for key segments of the population to better address their specific health care needs and improve their quality of life.

The ministry is striving to build a health system that provides patient-centred services that respond to a continuum of needs over an individual's lifetime. Most people will need a range of services:

- to help stay healthy with prevention and promotion services;
- to improve health and wellness with episodic care;
- to live with illness or disability by accessing chronic disease management or care; and
- to cope with the end-of-life through hospice or palliative care.

Clearly, one size does not fit all in health service delivery. For instance, the small number of patients who currently need and use health services the most are moving in and out of the health system constantly. These patients tend to have multiple chronic and/or terminal illnesses. Evidence shows our health system does not provide these patients with optimal seamless care and that improvements in care and outcomes can be made through innovation in our models of service delivery.

The ministry is working with health authorities and physicians to design and deliver customized care that addresses the unique needs of specific patient sub-populations. To begin, the focus is on coordinating care for patients with extensive needs, proactively managing chronic diseases, providing better care for the dying, and addressing health inequalities in BC's Aboriginal population. Implementing a patient-centred approach for these populations can improve quality of life and health outcomes for patients and provide better use of health services.

Priority Strategy 6: Better Care for People with Extensive Care Needs: Provide integrated care and targeted services for patients who have extensive health care needs to more effectively manage their contact with health care services.

A 2003 study shows a small percentage of BC's population uses a large percentage of medical services. For instance, the data analysis shows that in hospitals, five per cent of patients account for 54 per cent of bed days and 94 per cent of days spent in hospital after the need for hospital care has ended. This data has led the ministry to initiate a project to study the most frequent users of the system to find more effective ways of delivering their care. The ministry has been working with health authorities to better understand the common health concerns of this population and to develop evidence-based strategies to improve care.

Research shows other jurisdictions have improved care and reduced costs by introducing specific strategies for high needs populations. For example, providing intensive targeted care in the community to the frail elderly, such as medical, rehabilitative, social and support services, improves their health and reduces the number of hospital admissions, ambulance calls and drug claims. Other examples with similar results include improved end-of-life care and accessible community services for individuals with mental illness.

PS – Performance Measure 10: Percentage of days spent by highest needs patients in hospitals after the need for hospital care ended, measured by alternate level of care days as a percentage of total hospital inpatient days for these patients.

A key component of the high needs project is to evaluate the impact of new initiatives. Evaluation and performance measurement will assist the ministry and its partners to improve services for high needs patients.

As the project is still in its initial stages, specific performance measures have not yet been developed. As an interim performance measure the ministry will monitor the percentage of alternate level of care (ALC) days that high needs patients spend in hospital. For this patient group, ALC days are twice the average compared to the entire population. A reduction in ALC days will indicate more appropriate care options are available for this group.

At the time of publication, 2003/04 data is not available for high needs ALC days. The following table, however, provides some historical data and shows recent trends. In the 2004/05 service plan, the ministry has targeted a five per cent decrease in the high needs ALC rate.

	Fiscal Year				
	1999/00	2000/01	2001/02	2002/03 Baseline	2003/04* Target
Annual Target					–5.0%
ALC Days	348,740	376,668	352,355	311,397	N/A
Inpatient Days	1,479,519	1,491,181	1,469,593	1,430,004	N/A
Per cent ALC Days	23.6%	25.3%	24.0%	21.8%	N/A
➔ Per cent Change in per cent ALC Days from previous year	N/A	7.2%	–5.1%	–9.2%	N/A

* 2003/04 — data not available

Data Source: Discharge Abstract Database (DAD), March 2004, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services.

Notes: The top 5% of hospital users is selected based on total days of hospital care during the year, and comprises a different group of individuals every year.

Priority Strategy 7: Better Care for People with Chronic Conditions: Increase the emphasis on the effective management of chronic diseases (e.g., diabetes) to prevent or slow disease progression.

A chronic disease is an illness that cannot be cured completely. Diabetes, depression, congestive heart failure, hepatitis C and asthma are all chronic diseases. An estimated 500,000 British Columbians suffer from one or more chronic diseases.

Effective management helps people with chronic diseases stay healthy and independent for as long as possible. The ministry and its partners have completed initiatives to ensure patients receive the highest standard of chronic disease management and care. Best practices and clinical guidelines have been developed for congestive heart failure, diabetes and other chronic diseases. In addition, in September 2003, the ministry launched a two-year project called the Full Service Family Practice Incentive Program. This program aligns physician payment with quality care and provides additional remuneration for services delivered according to guidelines, as well as compensating physicians for participating in quality improvement learning collaboratives. Finally, the ministry has created chronic disease patient registries to monitor the impact of improving care, and other web-based tools to support physician practice.

PS – Performance Measure 11: Adherence to clinical best practices for managing chronic diseases measured by use of evidence-based quality benchmarks. (Will report on diabetes for 2003/04; other major chronic conditions to be added in subsequent years).

Diabetes: Percentage of patients with diabetes receiving at least two blood glucose (HbA1c) tests during the year.

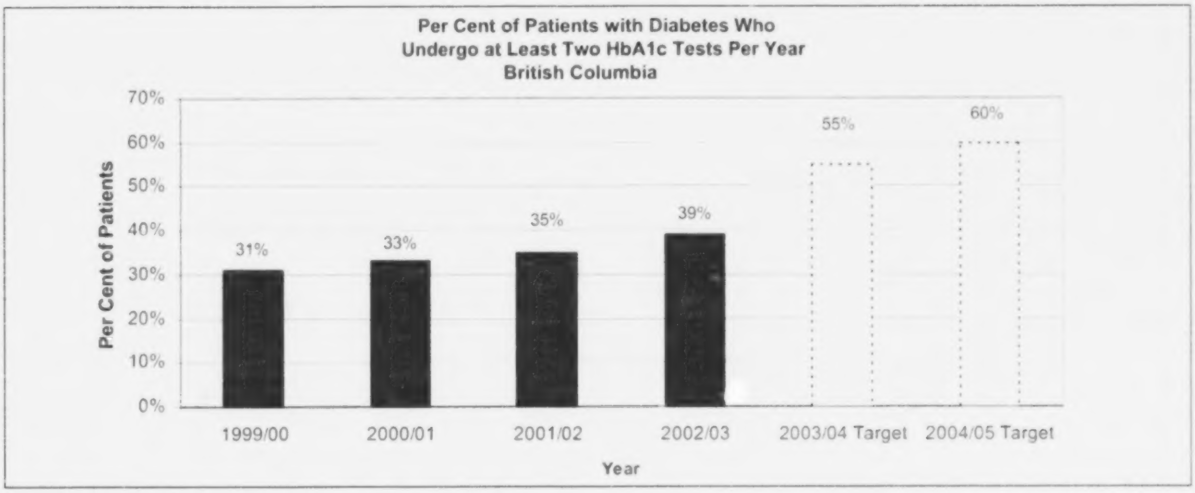
Diabetes is one of the most common chronic diseases, affecting about five per cent of Canadians; its prevalence is expected to increase significantly due to an aging population and rising rates of obesity. One component of effective diabetes care is to regularly monitor blood glucose levels. Blood glucose tests help flag potential complications for people with diabetes and allow care providers to help patients before their condition deteriorates.

Results:

2003/04 Target	2003/04 Actual	Status
55%	N/A	Pending

	Fiscal Year					
	1999/00	2000/01	2001/02	2002/03	2003/04*	2004/05
Annual Target				45%	55%	60%
Per cent of patients with diabetes who undergo at least two HbA1c tests per year	31%	33%	35%	39%	N/A	

* 2003/04 — data not available.



* 2003/04 — data not available.

Data Source: Physician Framework Supply (PFS), Information Resource Management; Medical Services Branch, Medical and Pharmaceutical Services, Ministry of Health Services (project 2004_014cmt).

Discharge Abstract Database (DAD), Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services.

PharmaNet, PharmaCare Branch, Medical and Pharmaceutical Services, Ministry of Health Services.

Analysis: From 1999/00 to 2002/03, the percentage of diabetes patients getting two HbA1c tests increased gradually from 33 per cent to 39 per cent. With the introduction of the BC Diabetes Care Guideline and the chronic disease management incentive payment in 2003, the ministry and its partners are tackling systemic barriers to accelerating the pace of change in diabetes care.

PS-Performance Measure 12: Use by physicians of appropriate drug therapies to slow or stop the progression of chronic diseases: Percentage of patients suffering from congestive heart failure who are prescribed:
a) ACE inhibitors;
b) Beta blockers.

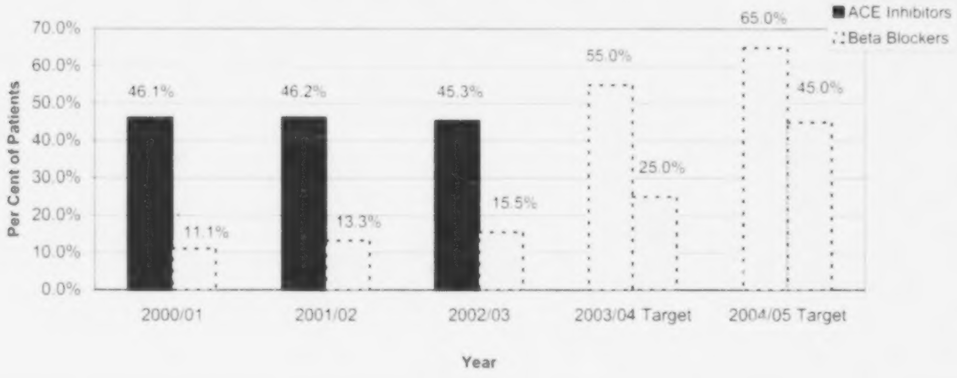
Over 37,000 British Columbians suffer from congestive heart failure — a chronic disease where the heart is unable to pump enough blood to meet the needs of the body's tissues. Research shows ACE inhibitor and beta blocker drugs, in combination with other treatments, significantly improve health outcomes for congestive heart failure patients; however, the rate of prescription for these drugs does not reflect the highest standard of care. In 2003/04, the ministry and its physician partners embarked on a broad-based collaborative to address and overcome challenges to increasing appropriate prescription rates of ACE inhibitors and beta blockers.

Results:

2003/04 Target	2003/04 Preliminary	Status
a) ACE Inhibitors 55%	N/A	Pending
b) Beta Blockers 25%	N/A	Pending

	Fiscal Year				
	2000/01	2001/02	2002/03	2003/04*	2004/05
ACE Inhibitors					
Annual Target			45.0%	55.0%	65.0%
Per cent of patients with CHF who are prescribed ACE Inhibitors	46.1%	46.2%	45.3%	N/A	
Beta Blockers					
Annual Target			17.0%	25.0%	45.0%
Per cent of patients with CHF who are prescribed Beta blockers	11.1%	13.3%	15.5%	N/A	

Per Cent of Patients with Congestive Heart Failure (CHF) Who Are Prescribed ACE Inhibitors and Beta Blockers British Columbia



* 2003/04 — data not available.

Data Source: Physician Framework Supply (PFS), Information Resource Management, Medical Services Branch, Medical and Pharmaceutical Services, Ministry of Health Services (project 2004_007cmt).

Discharge Abstract Database (DAD), Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services.

PharmaNet, PharmaCare Branch, Medical and Pharmaceutical Services, Ministry of Health Services.

Analysis: In the past, advances in care based on best-published evidence have diffused slowly. The Congestive Heart Failure Collaborative, which brings together the ministry and physicians, aims to change this. Starting in 2003 and concluding in May 2004, the collaborative has explored how to overcome systemic barriers to adopting best practices in care for congestive heart failure. From this work, the BC Congestive Heart Failure Guideline has been developed, along with a financial incentive program for treating patients according to the guideline. Performance is expected to improve slightly in 2003/04 and more rapidly thereafter. Annual figures cannot be calculated until after the Medical Services Plan year-end — the end of September following the fiscal year.

Priority Strategy 8: Better Care for the Dying: Expand palliative care services to provide dying people with greater choice and access to services.

Palliative care is the specialized care of people who are dying; it is an integral part of a health system that meets the needs of people across their lifespan. Good palliative care is provided, where possible, in the setting of a person's choice and is delivered by coordinated teams of physicians, nurses and other health professionals such as pharmacists and nutritionists, and includes family input and volunteer services.

The ministry is developing a Provincial Strategy for End-of-Life Care. In 2003/04, the ministry worked with partners, including health authorities, physicians and the BC Hospice Palliative Care Association, to enhance and coordinate palliative services across the province. In BC, publicly funded palliative care includes care provided in palliative care units or hospices in hospitals, as well as care provided in a person's home or other community-based setting. To promote innovative palliative care services, the ministry has introduced the Palliative Benefits Program, which provides medications, medical supplies and equipment to those who choose to die at home. Previously, those items were only covered if the patient stayed in the hospital. The Palliative Benefits Program is an important resource that allows health authorities and care providers to design programs to support people who choose to die at home or in settings outside the hospital.

PS – Performance Measure 13: Percentage of patients in BC accessing the home-based PharmaCare Palliative Plan in the 12 months prior to death.

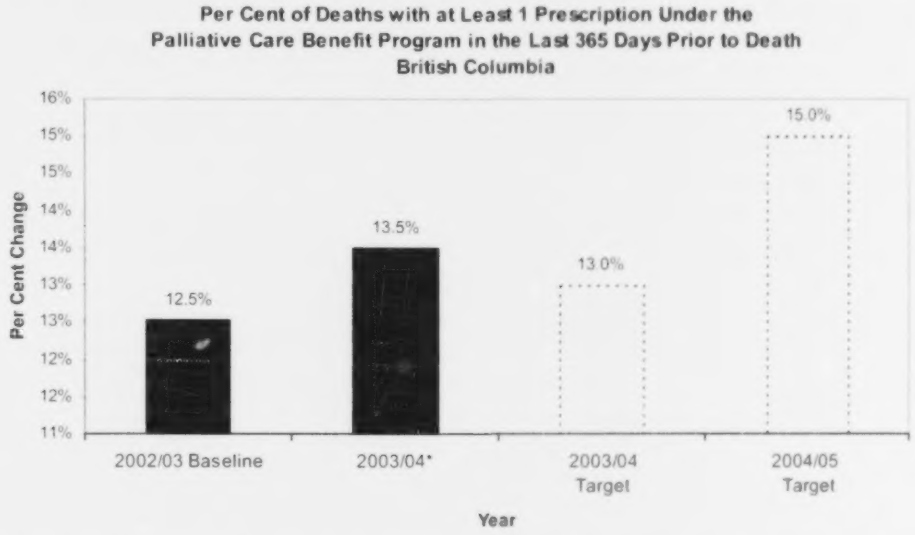
In the 2003/04 service plan, the ministry stated its intention to develop a performance measure for palliative care. On an interim basis, the ministry will be monitoring and reporting the percentage of people accessing benefits under the Palliative Benefits Program. Although this measure only captures one component of palliative services, it does indicate broader access to palliative care based on the assumption that clients who access the benefits program are likely accessing other palliative services, such as physician, home nursing or hospice care.

In the future, this indicator will be replaced with a more specific measure of access to palliative care. The development of a new measure is discussed in the analysis below.

Results:

2003/04 Target	2003/04 Preliminary	Status
13%	13.5%	On track

	Fiscal Year		
	2002/03	2003/04*	2004/05
Annual Target	Baseline	13.0%	15.0%
Deaths in fiscal year	28,012	8,115	N/A
Number of deaths with at least 1 prescription under Palliative Care Benefit Program	3,508	1,095	N/A
➔ Per cent of deaths with at least 1 prescription under Palliative Care Benefit Program	12.5%	13.5%	N/A



* 2003/04 partial year data (April 01 to July 31).

Data Source: HNData, Policy Development and Management, PharmaCare. Death Records, Vital Statistics Agency, Ministry of Health Services.

Analysis: Drug benefits under BC's Palliative Benefits Program have been available since 2001. The continued enhancement of palliative care, and especially community-based services, will likely lead to further increase in the use of these benefits.

While measuring the percentage of people accessing palliative benefits gives an indication of the availability of palliative services, it does not monitor the appropriateness and effectiveness of service, or its quality. Currently, the health system cannot measure the performance of palliative services in that detail. However, under the banner of the

Provincial Strategy for End-of-Life Care, the ministry's partners (health authorities and health professionals) will review and refine reporting mechanisms that identify the extent and scope of palliative care service delivery, and develop comprehensive indicators to monitor the benefit of providing palliative care services. Broader indicators will incorporate community-based services, such as direct care nursing and home support, hospices, enhanced services that support residents in their own care facility, general and specialist palliative physician services, and hospital bed days related to palliative care service delivery, as well as the percentage of clients accessing drug benefits.

Until that work is completed, the ministry will continue to use the percentage of people accessing palliative care benefits as a proxy indicator for the availability and uptake of palliative care.

Priority Strategy 9: Improve the Health Status of Aboriginal Peoples: Support initiatives to improve Aboriginal health through the formalized participation of Aboriginal people in the planning and delivery of health care.

As a group, Aboriginal people have a level of health below that of the general population. To address this inequity, the ministry is working with Aboriginal health care partners and stakeholders to develop a Provincial Aboriginal Health Services Strategy. This provincial strategy will contribute toward improving Aboriginal health by providing strategic guidance and examples of best practices for Aboriginal organizations and health authorities. A provincial steering committee of key stakeholders and representatives are working together to develop this strategy. These include the First Nations Summit, Provincial Aboriginal Health Organizations, Community Health Associates of BC, Pacific Association of First Nations Women, and the BC Aboriginal Network on Disabilities. Each health authority has also worked with Aboriginal communities and organizations to develop an Aboriginal health plan to guide current service delivery in their regions.

The ministry has also been working with the federal government and Aboriginal groups to develop a comprehensive Aboriginal health database to identify populations, incidence of chronic disease (such as diabetes) and access to standardized treatment resources. In early 2003, the BC First Nations Health Handbook, a new companion guide to the BC HealthGuide Handbook, was distributed. This handbook provides information on unique health services for First Nations, as well as advice for health professionals serving First Nations individuals and communities.

By focusing on Aboriginal health issues and involving Aboriginal communities in the planning of health services, we can ensure the Aboriginal population has access to the services and information needed to improve its overall health status.

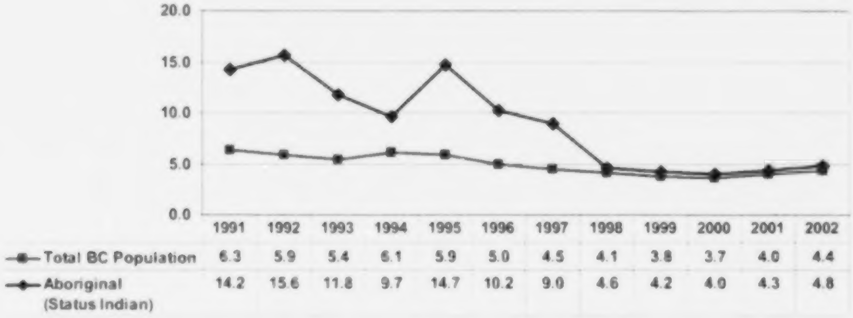
PS – Performance Measure 14: Improved health status for Aboriginal peoples measured by infant mortality and life expectancy.

The Ministry of Health Services tracks infant mortality rates and life expectancy because they serve as useful indicators of the overall health status of Aboriginal people. Data for 2003 is not available; however, data for the past decade is presented and provides useful insight for trends in Aboriginal health status.

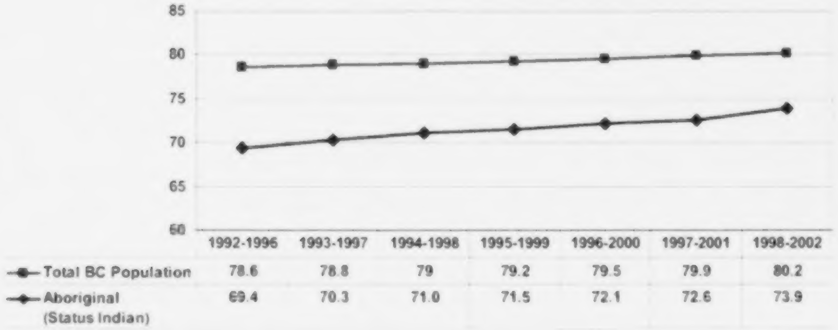
Results:

2003/04 Target	2002 Actual	Status
No statistically significant difference in infant mortality rates between Status Indians and other residents of BC	Infant mortality per 1,000 live births in 2002: Aboriginals = 4.8 per 1000 Total BC population = 4.4 per 1,0000	On track
Improvement in Status Indian life expectancy	Life expectancy in 2002: Aboriginals = 73.9 years Total BC population = 80.2 years	On track

Infant Mortality Rates per 1,000 Live Births



Life Expectancy of Aboriginal Peoples (Status Indian) Compared to the Total BC Population



Data Source: BC Vital Statistics Agency, BC Stats.

Analysis:

Infant Mortality Rate: Since 1990 in BC, the infant mortality rate for the Aboriginal Status Indian population declined from a high of 15.6 per 1,000 live births in 1992 to a low of 4.0 in 2000. Over the past decade, the gap between infant mortality rates in the Aboriginal population and the total BC population has decreased to being statistically insignificant. This is a vast improvement over the mid-1990's when the Aboriginal rate was over double the provincial rate.

Specifically, there are two components to the infant mortality rate, neonatal (< 28 days) and post-neonatal (28-364 days). The Status Indian neonatal rate is lower (but not statistically significant) than for other BC residents, while the Status Indian post-neonatal rate is higher (this is statistically significant). The Status Indian overall infant mortality, while not significantly different than for other BC residents, does not reflect that Status Indian infants are at a higher risk of post-neonatal mortality — the major cause of death being Sudden Infant Death Syndrome (SIDS).

Low income and education are key risk factors for SIDS, and predominant in the Status Indian population. Mitigative measures include avoiding smoking during pregnancy and around babies, putting babies to sleep on their backs, and breastfeeding. These modifiable factors are addressed through the Aboriginal Tobacco Strategy and multiple regional programs delivered by health authorities through the Aboriginal Health Initiatives Project.

Life Expectancy: For British Columbians, life expectancy (five-year average) has increased steadily in the last decade from 78.6 to 80.2 years in the general population, and from 69.4 to 73.9 years in the Status Indian population. Although still less, Status Indian life expectancy is growing faster than the general population, so the gap is gradually closing in both absolute and relative terms. This positive trend is expected to continue.

Core Business: Services Delivered by Partners *(continued)*

Goal 2: Improved Health and Wellness for British Columbians

Objective 3: Keep people as healthy as possible by preventing disease, illness and disability, and by slowing the progression of chronic illness to minimize suffering and reduce care costs in the future.

While British Columbians in general are among the healthiest people in the world, certain segments of the population do not share that status. Many citizens are still at risk from factors such as poor dietary habits, obesity, inactivity, accidents and tobacco use. In addition to poor health, the consequence of preventable illness is that vast resources are spent "after the fact" — once a disease or injury has occurred.

In these cases, an ounce of prevention is worth a pound of cure. Services such as public health protection, illness and injury prevention, and chronic disease management are important for maintaining and improving health outcomes, while containing overall health system costs. If we can support British Columbians' efforts to stay healthy and out of the health system, we win on two fronts: people achieve better health, and scarce resources can be used to provide appropriate care for non-preventable illness.

The ministry and its health care partners have used two main approaches for keeping people healthy. The first is to provide health information and resources to support people to manage their health and reduce the burden of disease, injury and disability. The second is to provide effective public health services to prevent illness and disability. These include immunization programs, infectious disease prevention and control, and monitoring and regulating water, food and environmental safety.

Priority Strategy 10: Enhancing Self Care and Self Management: Support individuals' self management efforts to help healthy people stay healthy and allow people with chronic conditions to better manage their condition.

Caring for a chronic disease, injury or illness does not begin or end at the doctor's office. In order to stay healthy, or manage diseases like congestive heart failure and diabetes, patients must also participate and take responsibility for their own care. By monitoring their health, improving their diet and getting exercise, patients get the best care possible.

The ministry and its health care partners support British Columbians in their efforts to stay healthy. The province has launched a wellness and prevention initiative, which includes Action Schools! BC that addresses elementary students' physical activity levels and lifestyles. In addition, the province has formed the Provincial Chronic Disease Prevention Alliance to strengthen chronic disease support and prevention. Through the BC Nurseline and other components of the BC HealthGuide Program, British Columbians now have access to health information, advice and resources 24-hours, every day.

PS – Performance Measure 15: Patient use of self-management techniques measured by use of evidence-based quality benchmarks. For 2003/04 will report on percentage of patients with diabetes receiving at least 2 blood glucose (HbA1c) tests during the year.

Developing performance measures for increases in physical activity and self-management of health conditions is difficult. Ultimately, the best indicators are improvements in health status and outcomes, which are measured over long periods of time. These indicators can be found in the Provincial Health Officer's Annual Reports, available on the ministry's Website (http://www.healthservices.gov.bc.ca/pho/ar/index.html).

In the 2003/04 service plan, the ministry signaled its intention to track HbA1c tests as an indicator of patient self-management. With the right tools and information, patients with diabetes are aware of the importance of receiving two HbA1c tests a year and are proactive in ensuring the tests are scheduled and the results discussed with their physician.

This indicator is also used as a performance measure under Priority Strategy 7. For results and analysis please see page 39.

Priority Strategy 11: Protection from Disease or Injury: Protect public health by implementing core public health prevention and protection programs (e.g., falls prevention, immunization, and food and water safety programs).

Government plays an important role in monitoring population health and protecting public health. Legislation and regulation of food, air and water quality lays the foundation for communities and citizens to live in healthy and safe environments. Programs that target and prevent certain diseases, like influenza, also contribute to maintaining and improving the health of British Columbians. In May 2003, the ministry brought into force the new *Drinking Water Protection Act*. Under the Act, health authorities have hired drinking water officers to help ensure British Columbians continue to enjoy clean, safe drinking water.

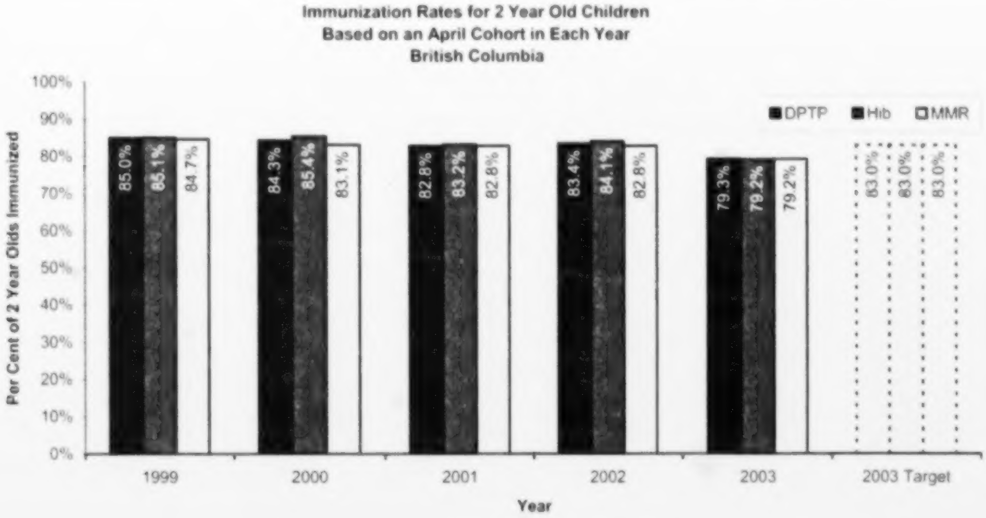
PS – Performance Measure 16: Immunization rates.
a) Two-year olds with up-to-date immunizations.
b) Influenza vaccination, population age 65 and over.

a) Immunization Rates for Two-year Olds: Immunization programs for children are among the most cost-effective ways to improve population health, prevent illness, and reduce health care costs. In BC, all infants and preschool children have access to immunizations, protecting them from the following nine diseases: diphtheria, tetanus, polio, pertussis, haemophilus influenza type b, mumps, measles, rubella, and hepatitis B. In July 2003, the ministry introduced meningococcal C conjugate vaccine to all infants 12 months of age. In the fall of 2003, pneumococcal conjugate vaccine was introduced to infants starting at two months of age.

Results:

2003/04 Target	2003/04 Actual	Status
83%	79.2%	Did not achieve target

	Fiscal Year				
	1999	2000	2001	2002	2003
Annual Target					83.0%
DPTP	85.0%	84.3%	82.8%	83.4%	79.3%
Hib	85.1%	85.4%	83.2%	84.1%	79.2%
MMR	84.7%	83.1%	82.8%	82.8%	79.2%


Immunization Rates for 2 Year Old Children
Based on an April Cohort in Each Year
British Columbia

Note: BC average only includes Northern Health Authority, Interior Health Authority and Vancouver Island Health Authority.

Data Source: Data are submitted by health authorities based on an audit of Child Health Record, records may be electronic or paper. A provincial summary is compiled by the Population Health and Wellness Division, BC Ministry of Health Services.

Notes: For 1999 to 2003 data, rates are based on a one-month cohort sample of children who turn two in April and for whom health authorities either have an electronic health record in i-PHIS or a paper health record — Hlth 182.

The data is not directly comparable between years as there have been several boundary changes since 1999.

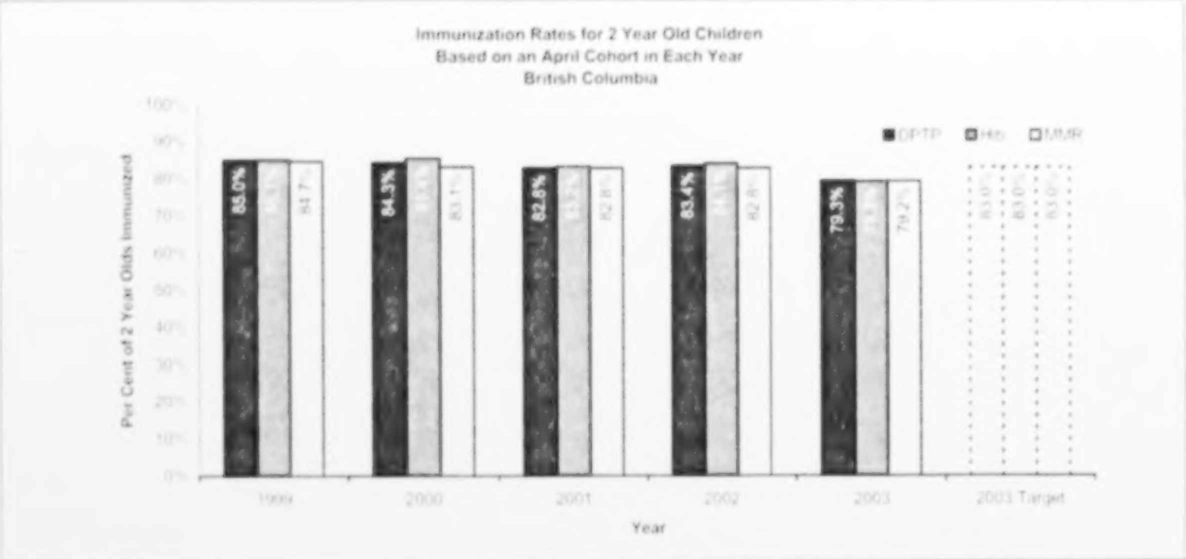
Currently there are no provincial standards for immunization data, therefore each Health Authority may have a different set of business rules for inputing data, activating and inactivating records and conducting audit practices.

The sample size for the April cohort is small, therefore the results may not necessarily be representative of all two year old children in the population.

Results:

2003/04 Target	2003/04 Actual	Status
83%	79.2%	Did not achieve target

	Fiscal Year				
	1999	2000	2001	2002	2003
Annual Target					83.0%
DPTP	85.0%	84.3%	82.8%	83.4%	79.3%
Hib	85.1%	85.4%	83.2%	84.1%	79.2%
MMR	84.7%	83.1%	82.8%	82.8%	79.2%



Immunization Rates for 2 Year Old Children
Based on an April Cohort in Each Year
British Columbia

Note: BC average only includes Northern Health Authority, Interior Health Authority and Vancouver Island Health Authority.

Data Source: Data are submitted by health authorities based on an audit of Child Health Record, records may be electronic or paper. A provincial summary is compiled by the Population Health and Wellness Division, BC Ministry of Health Services.

Notes: For 1999 to 2003 data, rates are based on a one-month cohort sample of children who turn two in April and for whom health authorities either have an electronic health record in i-PHIS or a paper health record — Hlth 182.

The data is not directly comparable between years as there have been several boundary changes since 1999.

Currently there are no provincial standards for immunization data, therefore each Health Authority may have a different set of business rules for inputing data, activating and inactivating records and conducting audit practices.

The sample size for the April cohort is small, therefore the results may not necessarily be representative of all two year old children in the population.

Analysis: Although data show a decrease in two-year-old immunization rates for 2003/04, results for the two largest health authorities, Vancouver Coastal and Fraser, are not included. For the remaining health authorities, the decrease is likely related to a number of factors. It is estimated between four and five per cent of the target population classifies as conscientious objectors, while others simply fail to get adequate immunization. Some decrease could also be linked to an increase in the required time per immunization visit as nurses are now required to provide more information on vaccine safety due to parental concerns and to provide up to three separate injections.

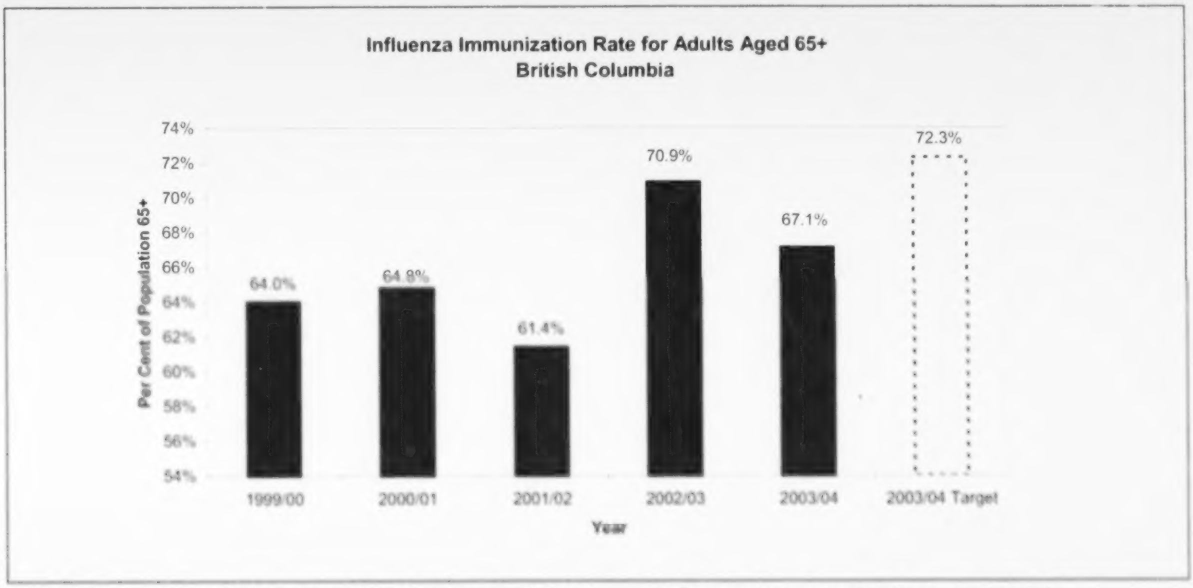
In January 2004, responsibility for this measure's data collection was passed to the BC Centre for Disease Control (BCCDC). The ministry has funded the BCCDC to improve, standardize, and monitor data collection, and analyze immunization programs and results.

b) Immunization Rates for Influenza Vaccination, Population Age 65 and Over: Influenza is a major cause of illness, hospitalization and death among older adults. Annual influenza vaccination reduces the risk of disease and may lessen the severity of illness.

Results:

2003/04 Target	2003/04 Actual	Status
2% increase over prior year	5.4% decrease	Did not achieve target

	Fiscal Year				
	1999/00	2000/01	2001/02	2002/03	2003/04
Annual Target				2.0%	2.0%
Influenza vaccination rate, 65+	64.0%	64.8%	61.4%	70.9%	67.1%
Percent change in influenza vaccination rate, 65+	15.3%	1.3%	–5.2%	15.5%	–5.4%



Influenza Immunization Rate for Adults Aged 65+
British Columbia

Data Source: Data are submitted by Health Authorities (Annual Influenza Immunization Program Survey). A provincial summary is compiled by Population Health and Wellness Division, BC Ministry of Health Services for 1999/2000 to 2002/2003. The BC Centre for Disease Control.

Notes/Data Limitations: Data are not comparable over all of the years. In 1999/2000 to 2001/2002 some health authorities reported on both the community-dwelling 65 + and the residents of long-term care facilities in this category.

2000/01 — incomplete data for the former health regions of Peace Liard and Capital Health.

2002/03 — data incomplete for Northern Health Authority; partial data available for the Northern Interior.

2003/04 — complete data available for Vancouver Island only.

2003/04 — A modified data collection form was used. These data may not be able to be compared to other years due to the change in definition of the type of facility.

Analysis: Data for this measure are unreliable, and currently not reflective of the whole population immunized. Many adults 65 and over access influenza immunization through a private physician's office — those immunizations are generally not captured by current reporting processes. However, like the previous measure, the BCCDC has been given the mandate to improve, monitor and collect data on influenza vaccination.

Notwithstanding the data challenges noted above, BCCDC reports a 16.2 per cent increase in doses distributed across the province in the 2003/2004 influenza season as compared to the previous year. This is a good indication of the success of the program.

Core Business: Services Delivered by Partners *(continued)*

Goal 3: A Sustainable, Affordable Health Care System

Objective 4: Manage within the available budget while meeting the priority needs of the population.

The ministry is committed to working with its partners to manage the health system efficiently to ensure resources are spent where they will have the best outcome. This objective, however, is about more than just keeping costs down — it is also about managing the system in such a way that services are provided effectively and in a high quality manner. With the move to six health authorities (there were 52 health authorities prior to 2002), a more streamlined, cost-efficient and accountable governance structure is in place, allowing more resources to flow directly to patient care. In delivering the full continuum of care to local residents, regional health authorities now have the flexibility to make decisions about what programs and services best meet the needs of local people. The result is more responsive and more accountable service.

Priority Strategy 12: Service Quality Enhancement for Rural and Smaller Communities: Consolidate services where necessary to ensure there is a critical mass of expertise to deliver services safely, cost-effectively and at a high quality.

Each health authority is creating networks of health and community services to provide quality, coordinated care. For example, by linking small community hospitals with basic emergency services to larger community and regional hospitals with more complex care capabilities, health authorities are able to provide high quality care and more timely access to multiple levels of service. A coordinated, integrated health system also improves accessibility to physician services, recruitment and retention of family physicians and specialists, and health outcomes for patients.

With many redesign initiatives of service delivery structures complete, the 2004/05 service plan refocuses this strategy on ensuring clinical services are organized safely, cost-effectively and at a high quality. Almost all types of medical treatment come with some risk of harm. This is obvious in the case, for example, of surgery or radiation therapy, but it also applies to drugs, many diagnostic tests and other types of treatment. To help ensure services are delivered as safely as possible, a province-wide task group was established in 2003 to review patient safety and develop guidelines, best practices and performance measures to improve patient safety. Performance measures developed by the task force will be included in future service plans and/or performance agreements.

Priority Strategy 13: Managing within Budget Allocation: Manage the delivery of services within budget.

When the new governance model for BC's health system and six health authorities was created in 2002, the government made it clear these new authorities would be expected to manage health care in their regions within their budgets. To enable better planning, health authorities were given three-year funding targets. As a transition measure, they were also given the flexibility to run deficits in 2002/03, provided they realized equivalent surpluses in 2003/04. In 2004/05 and subsequent years, health authorities must balance their budgets each year.

PS – Performance Measure 17: Administrative and support services expenditures by health authorities.

This indicator measures the amount health authorities spend on administrative and support services compared to their total expenditures. Administrative services include finance services, human resources and communications. Support services include maintenance, housekeeping, food services and security. To ensure maximum resources are directed to patient care, in 2002/03 health authorities were given a three-year target of reducing administrative and support services by seven per cent by the end of 2004/05 (compared to 2001/02 levels).

Results:

2003/04 Target	2003/04 Preliminary	Status
Reduction from 2001/02 administrative and support services expenditures by health authorities	Administrative and support expenditures reduced from 2001/02 totals	On track

Analysis: Audited financial statements are not available at the time of publication, but preliminary results indicate all health authorities have reduced their overall administrative and support expenditures from their 2001/02 totals. The savings realized from these changes will assist health authorities in meeting their financial performance targets and will ensure the maximum investment of public funding on priority health care issues within each region. All health authorities will continue to work towards the achievement of the seven per cent reduction target in 2004/05, although inflationary pressures and operational demands continue to present significant challenges.

PS – Performance Measure 18: Health authorities in a balanced budget position over the two year period 2002/03 – 2003/04 and then are balanced in each subsequent fiscal year.

Results:

2003/04 Target	2003/04 Preliminary	Status
Expenditures will not exceed revenues over the two fiscal years 2002/03 – 2003/04	Health authorities are in a balanced budget position over the two years	On track

Analysis: Audited financial statements are not available at the time of publication, but preliminary results indicate that overall, health authorities have achieved balanced budgets over the two years ending March 31, 2004. Reducing the number of health authorities from 52 to six along with the past two years of health service redesign initiatives have produced improved operating efficiencies, reductions to administrative and support expenditures, and changes to service delivery, each of which has contributed to the achievement of this performance target.

In 2004/05, health authorities become part of the Government Reporting Entity (GRE) and as such are subject to many of the same reporting, budgeting and financial requirements as the rest of government. In accordance with the *Balanced Budget and Ministerial Accountability Act*, government must balance the budget in 2004/05, including the operating results of all entities that are now within the GRE. Accordingly, balanced budgets are now a requirement for all health authorities.

Core Business: Services Delivered By Ministry

While the vast majority of health services are delivered in partnership with health authorities, physicians and other care providers, the ministry does deliver some services directly to the public. For this core business, the ministry has one key objective — to provide clients with equitable and timely access to services delivered directly by the ministry.

Goal 1: High Quality Patient Care

Goal 3: A Sustainable, Affordable Health Care System

Objective 5: Provide clients with equitable and timely access to services directly delivered by the ministry.

This objective focuses on improving the services the ministry currently delivers directly to the public. Priorities include better integration of ambulance services with other health services, and timely delivery of Medical Service Plan (MSP) and PharmaCare registration services and Vital Statistics services. The ministry must develop new models for delivering these customer services efficiently and effectively, while making the health system affordable.

Priority Strategy 14: Better Integrate the BC Ambulance Service within the Overall Health Services System: Review the ambulance service to ensure it is governed, managed and delivered by the most appropriate means and most appropriate providers to meet the needs of British Columbians.

The BC Ambulance Service (BCAS) is a key part of the health care system, providing pre-hospital treatment and transportation. The ambulance service operates 190 ambulance stations across the province and employs approximately 1,250 full-time and 2,000 part-time paramedic and dispatch staff.

The ministry is committed to ensuring the ambulance service delivers responsive and efficient care, and that the service is flexible and financially sustainable to meet the needs of BC patients now and in the future. To meet this commitment, the ministry is examining options and strategies to better integrate ambulance services with health authorities, to strengthen coordination of pre-hospital emergency care, and to better manage inter-facility transfers.

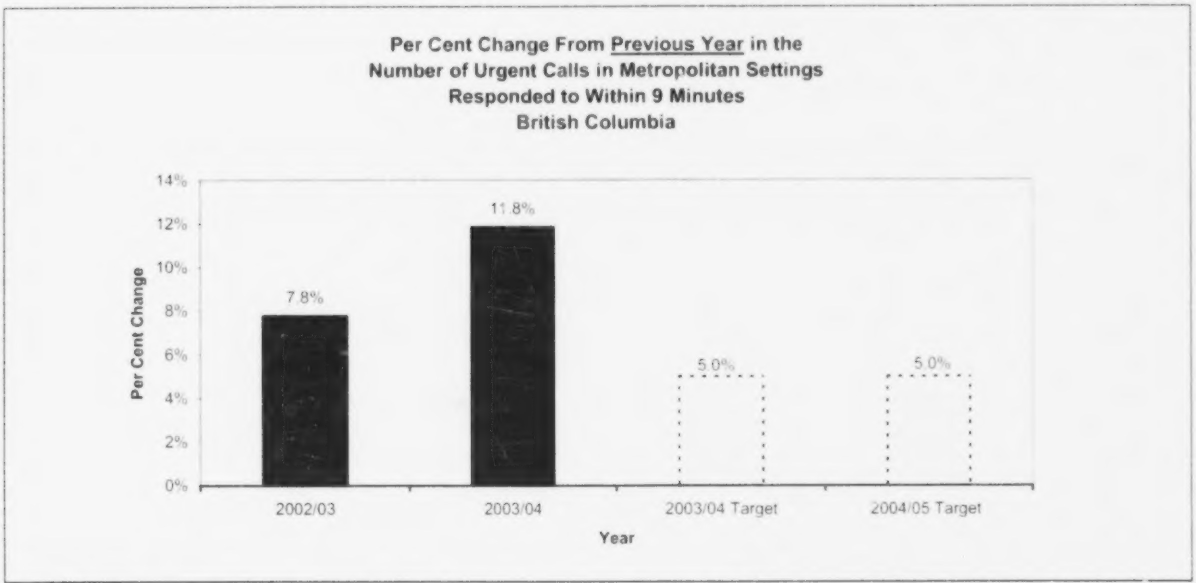
PS – Performance Measure 19: Ambulance service response rates.

This measure provides insight as to whether the ambulance service is performing its principal responsibility well — responding to sudden, acute care needs as quickly as possible. Many metropolitan Emergency Medical Services in Canada have adopted a response time goal of less than nine minutes, 90 per cent of the time. Although ideal to strive towards, meeting this goal in all communities can be difficult. Some areas are larger and less populated than others; therefore, it is unreasonable to expect ambulances in a large geographic region, such as Langley, to respond as quickly as ambulance services in a more densely populated region like Vancouver.

Results:

2003/04 Target	2003/04 Actual	Status
5% increase over prior year	11.8% increase	Met target

	Fiscal Year			
	2001/02	2002/03	2003/04	2004/05
Target		5.0%	5.0%	5.0%
Total number of urgent calls in metropolitan settings	19,899	21,542	22,798	N/A
Per cent of Responses within 9 minutes	53.8%	58.0%	64.9%	N/A
➔ Change in per cent of responses within 9 minutes	—	7.8%	11.8%	N/A



Data Source: 2001/02 — Management Information System (MIS), BC Ambulance Service, Ministry of Health Services. 2002/03 — DataMart (derived from CAD), BC Ambulance Service, Ministry of Health Services.

Analysis: Ambulance response times are the sum of the time it takes to assess a call (dispatch time), notify a responding ambulance crew (selection and notification time), mobilize the ambulance (chute time), and get to the patient (drive time).

In 2003/04, data show improvements in ambulance response times. Most improvements resulted from faster dispatch times through BCAS' rollout of a Computer Assisted Dispatch system in the Vancouver metropolitan area. This system has reduced dispatch times by improving mapping and area knowledge, automatically identifying locations of regular callers, and electronically signaling an ambulance crew dispatch for an emergency before all information has been collected.

To improve drive time, BCAS is working to reduce the time ambulances wait at emergency rooms. Not all people using the ambulance service require immediate care; however, paramedics are responsible for a patient once picked up, and they can get tied up at emergency rooms waiting for patients to be admitted. This reduces the number of ambulances on the road and lowers response times for subsequent calls. This is a primary reason the ministry is developing strategies to better integrate and coordinate ambulance services with health authorities and hospital services.

Priority Strategy 15: Improve Registration Services to the Public: Review the MSP and PharmaCare registration criteria and processes to ensure they provide appropriate and timely services to British Columbians and are managed and delivered by the most appropriate and efficient means.

The Medical Services Plan (MSP) provides coverage to beneficiaries for medically required services provided by physicians and some other health care practitioners. PharmaCare is the province's drug insurance program, which helps British Columbians by providing financial assistance toward eligible prescription drugs and medical supplies. The ministry operates the two programs, including registering BC residents who are eligible for coverage. The ministry has been working to improve registration services, and is currently negotiating an alternative service delivery arrangement with a private sector partner.

PS – Performance Measure 20: Percentage of the population adequately insured for eligible prescription drug costs.

The Fair PharmaCare Plan started on May 1, 2003. The new plan focuses financial assistance on BC families who need it most. Fair PharmaCare combines the previous major PharmaCare plans — the universal plan and the seniors' plan — into one, with assistance based on families' ability to pay. To receive their maximum level of financial assistance, individuals or families must register with the Fair PharmaCare Plan. BC families with the lowest incomes will receive immediate financial assistance under the Fair PharmaCare Plan. Other BC families will pay their full prescription drug costs until they reach their deductible. Once their deductible is reached, PharmaCare will assist families in paying for their eligible drug costs for the remainder of the year.

Results:

2003/04 Target	2003/04 Actual	Status
Establish baseline percentage of the population adequately insured	Baseline established at 67%	Achieved

	Fiscal Year	
	2003/04	2004/05
Annual Target	65.0%	73.0%
Eligible BC families	1,940,000	N/A
Number of Eligible BC families registered for Fair PharmaCare	1,299,000	N/A
➔ Per cent of Eligible BC families registered for Fair PharmaCare	67.0%	N/A

Data Source: Registration Database, 4 April 2004, Fair PharmaCare, Ministry of Health Services. eCorrespondence, Program Management, MSP Operations, Ministry of Health Services.

Analysis: In its first year, Fair PharmaCare registered just under 1.3 million families — 67 per cent of all eligible families in the province. Approximately 94 per cent of senior families have registered. Over 300,000 families have lower deductibles under Fair PharmaCare.

PS–Performance Measure 21: Turnaround times for MSP/PharmaCare (beneficiary) services to the public:

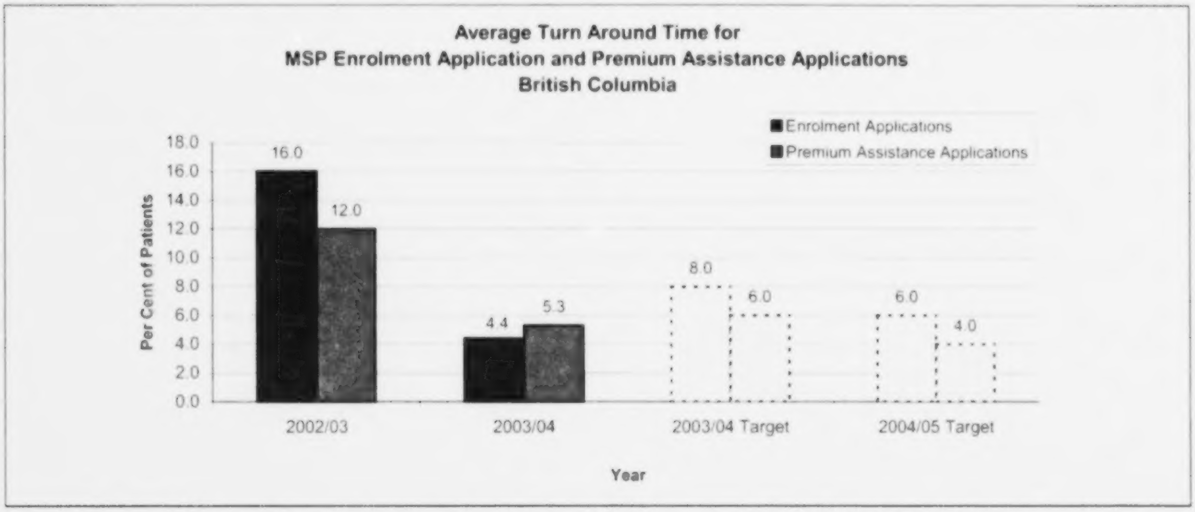
a) Enrolment applications;
b) Premium assistance applications.

Measuring the amount of time it takes for applications and premium assistance applications to be processed are key indicators of MSP/PharmaCare registration services. Enrolment applications are used for new or returning beneficiaries, while premium assistance applications are for beneficiaries whose income level makes them eligible for reduced premium payments.

Results:

2003/04 Target	2003/04 Actual	Status
a) 50% reduction in 2002/03 turnaround time or no greater than 8 weeks	72% reduction to 4.4 weeks	Met target
b) 75% reduction in 2003/04 turnaround time or no greater than 6 weeks	56% reduction to 5.3 weeks	Met target

	2002/03	2003/04	2004/05
Enrolment Applications			
Annual Target (weeks)	Baseline	8.0	6.0
Average turnaround rate (weeks)	16.0	4.4	N/A
Premium Assistance Applications			
Annual Target (weeks)	Baseline	6.0	4.0
Average turnaround rate (weeks)	12.0	5.3	N/A



Average Turn Around Time for MSP Enrolment Application and Premium Assistance Applications British Columbia

Data Source: eCorrespondence, Program Management, MSP Operations, Ministry of Health Services.

Analysis: BC's Medical Services Plan has made significant improvements in reducing times for enrolment and premium assistance applications, exceeding the 2003/04 service plan targets by a wide margin. Overall, processing time for enrolment applications has been reduced from the 2002/03 baseline of 16 weeks to 4.4 weeks — a reduction of 72 per cent. Significant improvements have also been made in eliminating backlogged applications; the ratio of applications over 60 days dropped from 61 per cent in April 2003 to only one per cent in April 2004.

For premium assistance applications, overall processing time was reduced from the 2002/03 baseline of 12 weeks to 5.3 weeks — a reduction of 56 per cent. The backlog of premium assistance applications was similarly reduced from 64 per cent of the inventory being over 60 days old in April 2003 to only one per cent a year later.

Two major strategies contributed to the ministry exceeding its targets for improving registration services. The first has been the implementation of a new management process, which included implementing an electronic document technology to increase efficiency. The second has been a partnership with an external call centre to handle routine inquiries, such as address changes, making more staff resources available to process applications.

VS Strategy 1: Provide Timely, High-Quality Vital Statistics Services to the Public: Pilot an electronic service for the registration of births and deaths; maintain customer satisfaction levels while implementing nationally mandated identification security measures; and improve direct electronic access to users of vital event health-related information products from the VISTA data warehouse to support health planning and surveillance activities.

VS – Performance Measure 1: Vital statistics registration turnaround times.

Results:

2003/04 Target	2003/04 Results	Status
40 days from date of event to complete registration for 90% of events reported	36 days	Met target

Data Source: British Columbia Vital Statistics Agency.

Analysis: The British Columbia Vital Statistics Agency exceeded its target for registering vital events. Data show an average of 36 days for completing 90 per cent of the registrations of birth, death, and marriage events and producing certificates.

The agency reduced registration completion times by 10 per cent from the previous year, mainly due to facsimile transmission of notices of births and registrations of deaths from hospitals and funeral homes, plus greater processing efficiencies of the award winning VISION system.

The agency will continue to explore strategies for further reduction of registration processing times. Reducing the time between the occurrence and report of vital events will enhance the validity of the data collected, thereby making it more valuable to health researchers and planners.

VS – Performance Measure 2: Customer and client (e.g., doctors, nurses etc.) satisfaction rates (courtesy, helpfulness, promptness).

Results:

2003/04 Target	2003/04 Results	Status
96% of customer satisfaction responses are satisfactory or better	97.2%	Met target

Data Source: British Columbia Vital Statistics Agency.

Analysis: The agency achieved an average percentage of 97.2 per cent for customer satisfaction for courtesy, helpfulness and promptness, exceeding the target of 96 per cent.

Since last year, the target has been reduced by one per cent due to a new security initiative that may have an effect on customer satisfaction. However, the Vital Statistics Agency has been able to maintain high satisfaction levels during the implementation period.

VS – Performance Measure 3: Expand scope of clients having access to Vital Statistics VISTA data warehouse.

Results:

2003/04 Target	2003/04 Results	Status
Electronic access to VISTA provided to primary users within the Ministry of Health Services	Electronic access to VISTA provided to primary users	Met target

Data Source: British Columbia Vital Statistics Agency.

Analysis: Access to the Vital Statistics data warehouse (VISTA) enables in-depth analyses of mortality and natality health issues to support health surveillance, program planning and monitoring, resource allocation, and health research by individuals and organizations engaged in these activities. In 2003/04, BC's Vital Statistics Agency successfully provided secure, web access to its VISTA warehouse to primary users of vital event information products within the ministry. The agency will continue to expand the scope of external client organizations accessing the VISTA warehouse.

Core Business: Stewardship

Goal 1: High Quality Patient Care

Goal 2: Improved Health and Wellness for British Columbians

Goal 3: A Sustainable, Affordable Health Care System

As steward of the health system, the ministry provides leadership and support to health authorities and other partners in delivering quality health services to the public. The ministry's stewardship objectives and strategies are designed to assist our service delivery partners fulfill the objectives and strategies listed in the previous section, and ensure the health system is redesigned in accordance with government's strategic direction. Stewardship strategies are organized under three objectives, which represent the main components of effective stewardship: Strategic Direction, Support to Partners, and Monitoring, Evaluation and Course Correction.

Each stewardship objective contributes to all three goals of the ministry. That is, effective stewardship by the ministry will contribute to a system with improved health and wellness for British Columbians, and high quality patient care that is sustainable and affordable.

The core business of Stewardship is where the functions of the former Ministry of Health Planning have been integrated with the Ministry of Health Services. This section reports our progress on performance measures from the 2003/04 - 2005/06 Service Plans for both the Ministries of Health Services and Health Planning. The format of this report follows the amalgamation of strategies from the two ministries as presented in the Ministry of Health Services 2004/05 - 2006/07 Service Plan. Each strategy and performance measure includes a notation indicating its origin (Health Services, Health Planning, or both). Performance measures that were discontinued following the amalgamation are included in this report and noted as such.

Unlike the previous sections of this report, most performance measures in this section are qualitative. Therefore, performance reporting is primarily based on detailing the ministry's progress in implementing its stewardship strategies.

Objective 1: Direction

The ministry is committed to leading and fostering a culture in which health system activities are evidence-based, well planned and understood, and in which accountability structures exist to ensure strategic directions guide service delivery activities. The ministry's strategic direction for the health system must be well articulated and communicated to the public and to those who deliver services to the public.

The ministry has undertaken several strategies to meet the objective of providing clear strategic direction for the health system. The following pages outline each of the strategies and report on the progress to date in meeting the performance expectations in the 2003/04 – 2005/06 Service Plan.

04/05 MOHS Strategy 1: Translate health care needs into clear strategic direction and measurable expectations that will guide operational management and delivery of health services.

03/04 Source: MOHS Strategy 1; MOHP Strategy 1.

To be effective the health system needs to be planned, well managed, responsive to patient and public needs and accountable to the public. We need to focus on the changing and diverse needs of British Columbians, and develop short and long-term strategies to ensure those needs are met. Those strategies must then be communicated and well understood by all stakeholders in the system, and accountability measures must be in place to ensure the delivery of services meets patient needs.

Performance Measure: Partners' ratings of the clarity, timeliness and usefulness of government direction in guiding service delivery (03/04 MOHS PM 1).

Target 03/04: TBD.

Actual 03/04: Survey tool and process under development.

Rationale: As the ministry strives to provide clear and timely direction to those who deliver health services, it is also important to receive feedback from the recipients of that direction. Working together will help identify strengths and gaps, and inform our efforts to clarify and improve our strategic direction and communication with our service delivery partners. To begin, we are developing and implementing a survey seeking the opinions of senior health authority personnel. This assessment tool will provide a comparable, clear measure of the ministry's performance over time.

Progress: The ministry is working with BC STATS to develop a survey and process, with implementation expected in 2004/05.

Performance Measure: Mid and long-term direction setting plans for the health sector completed. (03/04 MOHP PM 1).

Target 03/04: Health care system directional plan developed and service plan aligned with directional plan.

Actual 03/04: Analytical foundations complete, directional plan development underway.

Rationale: The health system is a multi-faceted, complex system. Planning for a social program as large as the health system occurs on many levels, in many places, and involves numerous health care partners, stakeholders and organizations. To ensure all components of the system are working toward the same goals, the ministry is developing an overall directional plan. The plan will detail the major strategies government will pursue to sustain and improve the publicly funded health system.

Progress: The ministry has completed the foundational work for the directional plan, including a comprehensive review of the health system and input from national and international experts. The long-term directional plan will be published in 2004/05.

04/05 MOHS Strategy 2: Facilitate the delivery of health services by partners through the development and use of best practice guidelines/standards and protocols.

03/04 Source: MOHS Strategy 3; MOHP Strategy 2.

Effective stewardship requires that the ministry not only provide strategic direction through broad planning, but also operational support through the research of best practices in service delivery. Scanning other health systems for best practices and incorporating them in BC can improve patient care and outcomes. The ministry works with professional groups, such as physicians and other health professionals, to research and develop best-practice guidelines, standards and protocols for use across the system.

Performance Measure: Strategic clinical practice guidelines in priority areas developed and implemented. (03/04 MOHS PM 3, MOHP PM 2).

Target 03/04: Develop and implement guidelines for palliative care, post-stay acute care, assisted living, hypertension, asthma, and depression.

Actual 03/04: Palliative care, assisted living, hypertension and asthma guidelines are developed and implemented. The depression guideline will be approved in early 2004/05.

Rationale: Best practice guidelines are an important and growing component of providing quality care. By researching the best outcomes and methods of delivering care across the world, and implementing those practices in BC, we can help ensure BC's patients are getting the best possible care.

Progress: In BC, guidelines and protocols are developed under the direction of the Guidelines and Protocols Advisory Committee (GPAC), jointly sponsored by the BC Medical Association and the Ministry of Health Services. BC has an active and successful program. Other guidelines approved in 2003/04 include: Diagnosis and Management of Sore Throat, Heart Failure Care, Evaluation of Chest Pain for Acute Coronary Syndromes, and a revision of the Diabetes Care guideline.

04/05 MOHS Strategy 3: Protect public health by articulating expectations for core public health prevention and protection activities including standards for their delivery.

03/04 Source: MOHP Strategy 4.

The goal of public health programs and initiatives is to protect health and prevent disease, injury, premature death and disability, and to improve population health. Public health functions encompass programs in four areas — health improvement, prevention of disease, disability and injury, environmental health and emergency health management — delivered using the public health strategies of health promotion, health protection, preventive services, assessment of population health and surveillance of disease.

The ministry is currently leading the development of core functions for public health. These will be mandatory public health programs and services that health authorities will be required to provide for the populations they serve.

Performance Measure: Priority programs developed for prevention and protection. (03/04: MOHP PM 4).

Target 03/04: Core programs delivery expectations and performance measures finalized.

Actual 03/04: Consultations completed, Core Public Health Functions Framework drafted.

Rationale: The ministry is working with health authorities to develop a set of public health core functions. These will include mandatory, legislated, long-term programs representing the minimum level of public health services that health authorities will be required to provide to their regions and communities. Each program will have clear goals, measurable objectives and an evidentiary base that illustrates effectiveness in protecting and improving people's health and preventing disease, disability and/or injury. The programs will also be supported through identification of best practices and national and international benchmarks. The identification and implementation of public health core functions will help ensure public health capacity within the health authorities remains focused on the most critical areas (i.e., those areas of public health with the greatest potential for positive impact).

Progress: The ministry has worked with health authorities, major professional councils and public health organizations to develop a Framework for Core Programs and Services in Public Health. Consultations were held throughout 2003, with a large stakeholder workshop in October 2003 to finalize the framework. Next steps include examining scientific and academic research on public health programs in BC and other jurisdictions, and developing core program performance expectations. Preliminary performance expectations have been developed for some core programs and included in the 2004/05 performance agreements between the ministry and health authorities.

04/05 MOHS Strategy 4: Enhance the quality and accountability of self regulated health care professionals in British Columbia by developing a regulatory framework to support and guide their work.

03/04 Source: MOHP Strategy 5.

Regulated health professions in BC have the privilege and responsibility to govern themselves in the public interest. Enhanced quality and accountability mechanisms are needed in response to emerging technology, new research, changing practice standards and higher public expectations for accountability of individual health professionals.

Performance Measure: Improved governance and accountability framework developed for the health professions. (03/04: MOHP PM 5).

Target 03/04: *Health Professions Act* (HPA) amended to clarify accountability and governance expectations for all colleges.

Actual 03/04: *Health Professions Amendment Act, 2003* (Bill 62) and *Health Professions Amendment Act (No. 2), 2003* (Bill 81) passed in Fall 2003.

Rationale: Effective self-regulation in the future will not be feasible without comprehensive, modernized legislation. There are currently 10 statutes regulating 24 professions, based on an exclusive scope of practice model. The province is working toward an umbrella regulatory framework under a single statute using a shared scope of practice/reserved actions model. This new framework will provide consistency and fairness in requirements relating to governance structures and transparency, registration processes, and inquiry and discipline matters. It will also facilitate development of common jurisprudence, counter perceptions of "hierarchy" among professions, enhance interdisciplinary practice, increase accessibility and consumer choice, and improve cost effectiveness.

Progress: Some provisions of Bill 62 were brought into force in December 2003. Most of the remaining provisions will be brought into force in 2004. Bill 81 will be brought into force by the end of 2004/05.

04/05 MOHS Strategy 5: Develop coordinated system-wide approaches for responding to major public health risks and epidemics (e.g., SARS, West Nile, meningitis and influenza outbreaks; childhood immunizations).

03/04 Source: MOHP Strategy 3.

The outbreak of SARS in 2003 demonstrated the importance of preparation, coordination and communication among health care partners and stakeholders to minimize the impact of communicable disease. Monitoring population health status and detecting and responding to outbreaks of disease and other health-related issues are key functions of the ministry and its partners.

Progress: BC has a solid track record in disease control and prevention. Key to this success is the BC Centre for Disease Control (BCCDC) — Canada's only comprehensive centre for disease control. The BCCDC has enabled BC to play a major national role in the coordinated, effective and rapid response to public health issues.

The SARS outbreak and response demonstrated the effectiveness of BC's health system in handling an urgent public health concern. In British Columbia, an alert was published and disseminated throughout the health system by BCCDC, and infection control precautions were immediately initiated for the first suspected case of SARS. The health system was able to mobilize staff and coordinate efforts quickly to respond in a number of key areas, including communications, surveillance, infection control, diagnosis and emergency management.

BC is taking a coordinated approach to controlling West Nile Virus, and planning has been underway for its likely arrival. The Ministry of Health Services is working with the Provincial Health Officer, the BCCDC, health authorities, local governments, and other ministries to plan appropriate mosquito control measures within each area's sphere of jurisdiction and responsibility.

Objective 2: Support to Partners

The ministry supports its service delivery partners (health authorities and health professionals) in achieving the strategic priorities of the health system. We develop provincial plans for the future supply and effective use of health care professionals, equipment, technology and facilities to ensure the health system has the capacity to meet the population's health needs. The ministry also supports health research and the development of best practices for service delivery, and develops legislative, regulatory and policy frameworks to manage the health system and protect public health and safety.

The ministry has undertaken several strategies to support its partners. The following pages outline each of the strategies and report on the progress to date in meeting the performance expectations in the 2003/04–2005/06 Service Plan.

04/05 MOHS Strategy 6:	**Make data accessible, with due attention to quality, security and privacy protection, to support evidence-based planning of patient care and clinical decision-making by partners (e.g., Electronic Health Record; CDM registries; inter-provincial/national data collection standards and registries).**
03/04 Source: MOHS Strategy 4.	

Decisions in the health care system should be based on evidence. The ministry is working with its partners to develop and strengthen data and information systems to build capacity for evidence-based strategic planning and decision-making. Following the Health CIO Council's publications of the *Strategic Plan for Health Information Management in BC*, and the *Framework for Electronic Health Record for British Columbians*, the province launched a number of key EHR projects, many of which were the result of collaboration between the ministry and the six health authorities, as well as collaboration at the federal and inter-provincial levels. Key EHR projects included the development of an electronic medical summary system, diagnostic imaging services, EHR architecture, and strategies for enabling movement of clinical messages (broker), physician involvement in electronic access to clinical information, uniquely identifying patients, and improving the uptake of the PharmaNet system and the Provider Registry by the health authorities.

Performance Measure: Clients' and partners' ratings of data availability and usefulness in supporting planning and service delivery. (03/04: MOHS PM 4).

Target 03/04: TBD.

Actual 03/04: Survey tool and process under development.

Rationale: Similar to the performance measure on government strategic direction and feedback, the ministry also wants to receive feedback from the health authorities on the usefulness of data supplied by the ministry. This feedback will help improve the way data is used to support decision-making in the health system.

Progress: The ministry is working with BC STATS to develop a survey and process, with implementation expected in 2004/05.

04/05 MOHS Strategy 7: Provide legislative, regulatory and policy frameworks to ensure policy direction is clear and consistent and that services are delivered appropriately and cost-effectively.

03/04 Source: MOHS Strategy 5; MOHP Strategy 6.

A core function of government is to provide the legislative governance framework for the health system. The ministry regularly assesses the need for new or amended legislation, regulation or policy to ensure the system operates in the public interest.

Performance Measure: Percentage of regulatory requirements reduced. (03/04: MOHP PM 6; MOHS PM 5).

Target 03/04: 2% reduction in regulations*.

Actual 03/04: 5.06%.

---

* Deregulation targets were restated in the ministry's 2004/05–2006/07 Service Plan to reflect the ministry's updated legislative plan.

Rationale: Government made a *New Era* commitment to reduce regulatory requirements by one-third across government. The ministry has been working to reduce regulatory requirements in the health sector to streamline and update the overall legislative framework and reflect an outcome-based approach. This work has been undertaken while recognizing the need to preserve those regulations which are essential to the protection of public health and safety.

Progress: The ministry continued its efforts during 2003/04 to reduce the regulatory burden in the health sector. Major regulatory reviews resulted in the reduction of 213 requirements, while 133 new requirements were enacted for a net reduction of 80. Significant streamlining related to health professional governance and statutory amendments is expected to achieve a further reduction of 10 per cent in 2004/05.

Performance Measure: Establishment of a regulatory framework to ensure appropriate utilization of the private sector in the provision of health care. (03/04: MOHP PM 7).

Target 03/04: Policy framework implemented.

Actual 03/04: Policy framework implemented.

Progress: The ministry developed a Patient Service Delivery Policy Framework to ensure appropriate use of private sector services in the provision of health care. The policy specifies parameters for when health authorities may purchase clinical services from private providers. The policy ensures this occurs only in situations that comply with the *Canada Health Act*, and only if government's criteria of patient benefit, value for money, and accountability have been met. Health authorities must comply with the policy when purchasing clinical services from private sector providers, and report all such arrangements in their annual Health Service Redesign Plans.

04/05 MOHS Strategy 8: Ensure the health care system has the capacity to meet the population's health needs by developing provincial plans for the supply and effective use of health care professionals, facilities, and infrastructure.

03/04 Source: MOHP Strategy 7.

The ministry has made a commitment to include longer-term planning in the management of the health system. This focus provides an opportunity to identify strategies that will effect systemic change in the health system for the long-term. Also, by involving health authorities in developing plans for health facilities and medical equipment, we can ensure capital funding is used in the best manner to meet the population's current and future needs.

Performance Measure: Health Human Resource, IT, and Capital plans developed. (03/04: MOHP PM 8).

Target 03/04: Health Human Resource Plan updated. Capital asset management planning process implemented. Hospital facilities, Intermediate and Long-term Care facilities, and Medical Machinery, Equipment and Technology plans developed.

Actual 03/04: On track — see progress section for details.

Rationale: Health human resource, information technology and capital planning all benefit from a province-wide perspective. Accordingly, the ministry is involved with health authorities and other partners (e.g., Ministry of Advanced Education, universities and colleges, Government of Canada) to ensure planning in these fundamental areas is integrated and coordinated to maximize benefits from investments and strategies.

Progress: Health human resource planning has focused on the education, recruitment and retention of physicians, nurses and other health professionals to ensure all regions of the province have appropriate care providers to meet patients' needs. Highlights include: almost 2,000 new education spaces for care aids, licensed practical nurses, registered nurses and midwives over the past three years, including 693 new places in 2003/04; expansion of medical school spaces from 128 to 224 by 2005; and establishment of a loan forgiveness program for medical, nursing, midwifery and pharmacy students who work in rural communities after graduation.

A new capital asset management planning process is in place. The Capital Asset Management Framework and multi-year budgeting process require provincial public sector agencies to submit annual capital asset management plans. This information is integral to the capital planning process and facilitates capital investment being targeted to support the ministry's service plan objectives. In this regard, the ministry has been focusing on three sectors of the health care system — hospital facilities, community care facilities, and equipment. For more information on capital planning and investments, please see page 82.

Information technology planning focused on provincial strategies for electronically linking patient and diagnostic information to improve care delivery, quality of clinical decision-making and efficiency. Highlights include developing an electronic medical summary system, diagnostic imaging services, EHR architecture, and strategies for enabling movement of clinical messages (broker), physician involvement in electronic access to clinical information, uniquely identifying patients, and improving the uptake of PharmaNet system and the Provider Registry by the health authorities.

04/05 MOHS Strategy 9: Support health research and create opportunities for health partners to share knowledge and best practices to facilitate continuous improvement in service delivery.

03/04 Source: MOHP Strategy 10.

Research, evaluation and information management are essential to enhancing our capacity to share knowledge and best practices to continually improve BC's health system. The Michael Smith Foundation for Health Research has a provincial mandate to help build BC's capacity for excellent health research. The foundation has a mandate to fund biomedical, clinical, population health and health services research.

In 2003/04, the province provided a $24 million grant to the foundation to support research to enhance the effectiveness of health care reforms and to continue to recruit and retain excellent health researchers. The grant is intended to fund rigorous evaluations of the impacts of key policy changes in the health system. The ministry and the health authorities have identified the following priority areas for research activity: acute care redesign, chronic disease management, home and community care, health human resources, specific populations and mental health services.

Objective 3: Monitoring and Evaluation

The ministry monitors and evaluates the delivery of services and the health of BC's population to ensure services meet patients' and the public's needs. As part of a commitment to continuous improvement and evidence-based decision-making, the ministry uses its evaluations of health system performance to inform strategic intervention and facilitate course correction if required.

The section contains the strategies and performance measures the ministry has adopted to enhance its monitoring and evaluation functions.

04/05 MOHS Strategy 10: Develop an effective monitoring and evaluation framework for services provided by health authorities and other system partners (e.g., health professions).

03/04 Source: MOHS Strategy 8.

Monitoring and evaluating the level, quality and impact of services delivered to the public by the ministry's partners is critical to ensuring the public receives value for health expenditures. The ministry must ensure patients are able to access appropriate services that meet their needs, while at the same time ensuring limited health funding is spent efficiently. To that end, the ministry has developed an accountability and performance monitoring framework for services delivered by health authorities. In 2002, for the first time in Canada, the ministry established performance agreements with each health authority that outlined expectations and performance targets. These performance agreements continue to be renewed annually, with modifications and improvements being incorporated as experience is gained.

Performance Measure: Health authority compliance with the performance agreement. (03/04: MOHS PM 7).

Target 03/04: 6/6 Health authorities will be in compliance.

Actual 03/04: On Track.

Rationale: Performance agreements set out direction and expectations for each health authority for health system governance and health service delivery. They contain specific targets for system performance improvements in key areas, such as emergency services, surgical services, mental health services, home and community care, public/population health, Aboriginal health, and support and administrative services. Each of these targeted improvements support achievement of the ministry's service plan goals and objectives.

Progress: Each health authority committed to a performance agreement for 2003/04. The ministry liaised with health authorities and monitored progress during the year. The ministry will publish a report on health authority performance for 2003/04 in January 2005, when final health system data is available for the 2003/04 fiscal year.

04/05 MOHS Strategy 11: Monitor financial status to ensure overall health system costs stay within budget.

03/04 Source: MOHS Strategy 9.

BC's health services budget has continued to grow — the ministry's budget for 2003/04 was over $10.5 billion and health spending consumed approximately 42 per cent of all government spending. It is important this funding is used wisely to provide the best care and achieve the best outcomes for patients — and that all parts of the system manage within their allocated budgets. The ministry monitors financial status throughout the year so any problems can be identified and addressed, and ensures overall costs remain within its budget.

Performance Measure: Overall health system financial status (actual expenses compared to budgeted expenses at year end) (03/04: MOHS PM 9).

Target 03/04: Expenses do not exceed budget.

Actual 03/04: Expenses did not exceed budget.

Progress: Overall health system expenses were under budget for 2003/04. For more details, please see the Resource Section on page 79.

04/05 MOHS Strategy 12: Monitor and report publicly on the health of the British Columbia population.

03/04 Source: MOHP Strategy 11.

Monitoring the health status of the population is essential for assessing the effectiveness of health programs and services. Health status is influenced by a number of factors including the social, economic and physical environment, personal health practices, individual capacity and coping skills, human biology, early childhood development, health services and gender and culture. While many of these factors lie beyond the jurisdiction of the health system, surveillance and assessment of population health assists government and the ministry address issues or trends and develop healthy public policy.

Performance Measure: Report annually on population health status or a significant health issue. (03/04: MOHP PM 9).

Target 03/04: Annual Report produced.

Actual 03/04: Report produced.

Rationale: The Provincial Health Officer (PHO) reports publicly each year on the health of the population. The PHO is the senior medical health officer for British Columbia and provides independent advice to the Minister of Health Services and the ministry on public health issues and population health.

Progress: In November 2003, the PHO released *A Report on the Health and Well Being of People in British Columbia, Provincial Health Officer's Annual Report 2002.* The Provincial Health Officer also released:

1. *A Review of Infant Mortality in BC: Opportunities for Prevention. A Report of the Provincial Health Officer,* October 2003;
2. *An Ounce of Prevention — A Public Health Rationale for the School as a Setting for Health Promotion: A Report of the Provincial Health Officer,* October 2003; and
3. *Prevention of Falls and Injuries Among the Elderly, A Special Report from the Office of the Provincial Health Officer*, January 2004.

These reports can be found on the ministry's Website at: http://www.healthservices.gov.bc.ca/pho.

Core Business: Corporate Management

The ministry must also manage its own operations efficiently and effectively. Corporate management includes managing ministry budgets, human resources and information needs. The ministry included two objectives for Corporate Management in its 2003/04 service plan.

Goal 3: A Sustainable, Affordable Health Care System

Objective 1: Appropriate organizational capacity to manage the health care system and efficiently deliver necessary services.

The ministry has significantly changed its role in the health system. In the past, the ministry was predominantly involved in the direct delivery of health services. Now, the ministry is primarily focused on being a steward of the health system. This change in focus has required the ministry to develop new areas of expertise, such as planning, monitoring and evaluating services delivered by other agencies. This objective, and the strategy and performance measure below, helps ensure the right mix of skills and abilities are available throughout the organization to successfully manage the health system.

04/05 MOHS Strategy 13: Implement Human Resource Management Plan for the Ministry of Health.

03/04 Source: MOHS Strategy 12; MOHP Strategy 12.

In order to achieve the strategic objectives in the service plan, additional effort must be focused on developing and supporting the ministry's employees, and continuing to build an enriching, rewarding and flexible organization. To do so, the ministry is implementing a human resource strategy. The strategy supports the Corporate Human Resource Plan for the Public Service of British Columbia. Its initial focus is on rebuilding and strengthening our organization and employees, developing a culture of learning, and achieving high levels of performance.

Performance Measure: Percentage of employees who indicated comprehension of vision, mission, and goals of the organization and their role in assisting to achieve these goals. (Annual Employee Survey) (03/04: MOHS PM 11; MOHP PM 12).

Target 03/04: 45%.

Actual 03/04: 29%.

	Fiscal Year		
	2002/03	2003/04	2004/05
Annual Target	Baseline	45.0%	65.0%
➔ Percentage of Employees who understood their role in achieving the Ministry's goals	22.5%	29.0%	N/A
Employee survey response rate	72.0%	55.0%	N/A

Data Source: Employee survey March 2003 and March 2004, BC STATS.

Rationale: In 2002/03, the ministry conducted its first annual survey of organizational health. The purpose of the survey is to measure satisfaction levels and to identify issues of importance to staff in six aspects of organizational health: communication, leadership, personal and professional development, quality of life, recognition and involvement. This performance measure has been chosen due to the importance of employees understanding their individual roles within the broader mission and goals of the health system.

Progress: The 2002/03 survey produced a baseline for this measure of 22.5 per cent. Some progress was made in 2003/04 survey results with the positive response rate increasing to 29 per cent. While the ministry had hoped for more rapid improvement, these results indicate a move in the right direction. In 2004/05, all employees will develop Employee Performance and Development Plans. Implementation of employee plans that directly link with organizational strategic plans is expected to greatly improve employees' understanding of their roles in achieving the ministry's vision and goals.

Objective 2: Sound management practices in place.

The first objective under Corporate Management is to have the appropriate personnel with the required skills and abilities in the ministry. The second objective is to have the business and operational practices in place to maximize the human resources and ensure the production of quality work. The ministry is committed to adopting sound management practices and operating in an innovative, enterprising, results-oriented and accountable manner.

04/05 MOHS Strategy 14: Embed sound business practices and a business management culture within the Ministry of Health.

03/04 Source: MOHP Strategy 13; MOHP Strategy 13.

The ministry is undergoing a cultural shift. This shift emphasizes structured business planning and performance monitoring as the new standard for doing business throughout the organization. In practical terms, this means that strategic priorities and operational plans and activities set at the division, department and individual level must be aligned with and contribute to the overall service priorities of the ministry and government. Integrated planning and performance monitoring will help ensure resources are focused on identified priorities.

Performance Measure: Percentage of divisions with integrated service (business) and HR plans. (03/04: MOHS PM 12; MOHP PM 13).

Target 03/04: 30%.

Actual 03/04: 50%.

Rationale: In adopting integrated planning, the ministry has focused initial efforts on the development of service or business plans for each division of the ministry. These plans present the activities each ministry division is undertaking to achieve the ministry's service plan goals, objectives and strategies. (The ministry has eight divisions. A division is an organizational unit headed by a Deputy Minister or Assistant Deputy Minister.)

Progress: Four of eight divisions in the ministry have completed plans detailing activities for the 2004/05 fiscal year. The remaining divisions have plans in progress; these will be finalized in early 2004/05. The ministry also introduced Employee Performance and Development Plans for management employees in 2003/04. Employee plans detail individual work goals, strategies and performance measures tied to the strategic objectives of the ministry. In 2004/05, all ministry staff will complete Employee Performance and Development Plans.

Discontinued Performance Measures

The following performance measures were contained in the Ministry of Health Services or Ministry of Health Planning 2003/04 – 2005/06 Service Plan. These measures were discontinued as part of the ongoing refinement of performance indicators.

Performance Measure: Commitments articulated in the 2003 Accord met. (03/04: MOHS PM 2)

Target 03/04: TBD.

Actual 03/04: Measure was discontinued.

Rationale: This measure was intended to include compliance targets for initiatives under the Federal/Provincial/Territorial Health Accord of 2003. The measure was discontinued because the ministry does not have sufficient control over the timing of target setting to make it a feasible service plan measure. Use of Accord funding, however, can be found in this report in the Resource Section on page 81.

Performance Measure: Development of a new *Public Health Act*. (03/04: MOHP PM 3).

Target 03/04: Regulations, policy and guidelines developed for new/revised legislation.

Actual 03/04: Measure was discontinued.

Rationale: Public health is currently governed under the *Health Act*. Work has begun to review the Act in light of modern public health legislation, with the intent of bringing forward recommendations for updating the existing Act. This work will continue, but this measure has been discontinued because it is not considered one of the few, critical areas of performance for inclusion in the service plan.

Performance Measure: Number of redundant or unnecessary policies eliminated from policy manuals. (03/04: MOHS PM 6).

Target 03/04: TBD.

Actual 03/04: Measure was discontinued.

Rationale: This indicator was originally adopted as a measure of the clarity and consistency of the ministry's policy direction to its service delivery partners. In practice it was an unworkable approach due to the labour intensity of reviewing all health sector policies. In its place the ministry will monitor success in providing clear direction through open communication with partners and by addressing clarity issues as they become apparent. The 2004/05 – 2006/07 Service Plan includes a performance measure (MOHS — Performance Measure 2, page 35 — health authorities' ratings of the clarity of government direction) which will provide a better indication of the ministry's success in providing clear policy direction.

Performance Measure: PharmaCare programs and policies reviewed for congruency with quality patient outcomes, program sustainability and transparency. (03/04: MOHS PM 10).

Target 03/04: Review completed and changes implemented.

Actual 03/04: Fair PharmaCare Plan implemented.

Rationale: The Fair PharmaCare Plan was introduced in May 2003. The new Plan is income-based in order to better provide a sustainable and equitable public drug benefit program focused on those with the greatest need.

The ministry will continue to monitor and evaluate the impact of the new plan on beneficiaries as well as on the overall sustainability of the PharmaCare program. Preliminary evaluations indicate drug utilization has not decreased in either senior or non-senior groups since the Plan's implementation. The ministry is also working with Harvard University and the University of British Columbia on a long-term evaluation of Fair PharmaCare which will continue until 2009.

Performance Measure: Public and patient satisfaction rates. (03/04: MOHP PM 11).

Target 03/04: Maintain 45-50 per cent public satisfaction rate and achieve 70 per cent patient satisfaction rate.

Actual 03/04: Measure was discontinued.

Rationale: A public satisfaction survey did not proceed in 2003/04. Instead, survey efforts were focused on sector specific patient satisfaction with surveys having been designed and implemented for the emergency room and long-term care sectors. Receiving feedback and input from the users of these services provides the ministry and health authorities with valuable information that can be used to improve services. General population surveys would not provide the same level of useful information and so the ministry and health authorities focused resources on patient specific surveys.

Performance Measure: Monitoring with respect to the Provincial Health Officer's recommendations (HIV, drinking water, Aboriginal health, air quality). (03/04: MOHP PM 10).

Target 03/04: Action taken on six priority recommendations with respect to drinking water quality.

Actual 03/04: Measure was discontinued.

Rationale: The ministry is developing a tracking process for the status of recommendations in Provincial Health Officer's reports. This process encourages relevant stakeholders to be accountable and cognizant of how their policies and functions affect the health and well being of British Columbians, and enables the Provincial Health Officer to follow up on issues in a logical and thorough manner.

The annual reports and the associated planning will continue, as will monitoring implementation of recommendations by the Provincial Health Officer. This measure was discontinued because it is captured in the ministry's regular operations and is not considered one of the few, critical areas of performance for inclusion in the service plan.

Report on Resources

	MoHS Estimated Total	MoHP Estimated Total	Total Estimated	Actual	Variance
Operating Expenses ($000)					
Services Delivered by Partners					
Regional Health Sector Funding	6,609,004	—	6,609,004	6,546,977	62,027
Medical Services Plan	2,551,892	—	2,551,892	2,539,725	12,167
PharmaCare	743,414	—	743,414	722,586	20,828
Debt Service Costs	172,300	—	172,300	150,917	21,383
Amortization of Prepaid Capital Advances	133,100	—	133,100	132,491	609
Subtotal	**10,209,710**	**—**	**10,209,710**	**10,092,696**	**117,014**
Services Delivered by Ministry					
Emergency Health Services	190,540	—	190,540	221,637	(31,097)
Health Benefits Operations	13,594	—	13,594	16,946	(3,352)
Subtotal	**204,134**	**—**	**204,134**	**238,583**	**(34,449)**
Stewardship and Corporate Management					
Minister's Office — MoHS	1,042	—	1,042	906	136
Program Management and Corporate Services — MoHS	89,861	—	89,861	97,803	(7,942)
Minister's Office — MoHP	—	467	467	292	175
Program Management and Corporate Services — MoHP	—	16,602	16,602	15,909	693
Subtotal	**90,903**	**17,069**	**107,972**	**114,910**	**(6,938)**
Vital Statistics	**—**	**7,085**	**7,085**	**6,688**	**397**
Recoveries from Health Special Account	**(147,260)**	—	**(147,260)**	**(147,260)**	**—**
Health Special Account	**147,260**	—	**147,260**	**147,260**	**—**
Medical and Health Care Services Special Account (MHCSSA)	**305**	—	**305**	**305**	**—**
Medical and Health Care Services Special Account (Elimination Entry)	**(305)**	—	**(305)**	**(305)**	**—**
Total	**10,504,747**	**24,154**	**10,528,901**	**10,452,877**	**76,024**

	MoHS Estimated Total	MoHP Estimated Total	Total Estimated	Actual	Variance
Ministry Capital Expenditures (CRF) ($000)					
Program Management and Corporate Services	8,188	—	8,188	7,210	978
Emergency Health Services	7,843	—	7,843	7,905	(62)
Vital Statistics	600	—	600	425	175
Total	**16,631**	**—**	**16,631**	**15,540**	**1,091**
Consolidated Capital Plan Expenditures (CCP) ($000)					
Prepaid Capital Advances	**202,500**	**—**	**202,500**	**139,670**	**62,830**
Other Financing Transactions ($000)					
Receipts	**2,034**	**—**	**2,034**	**6,769**	**4,735**
Full-time Equivalents (FTEs)					
Ministry of Health Services	**2,525**	**209**	**2,734**	**2,825**	**(91)**

Resource Summary Variance Explanations

Regional Health Sector Funding

This area was under budget due to the transfer of certain capital spending from the operating budget to the capital budget and the deferral of a portion of the federal equipment funding to subsequent fiscal years.

Medical Services Plan

This area was under budget due to lower than anticipated expenditures in rural health recruitment and retention programs, physician benefits and supplementary benefits. The under expenditure was partially offset by increased costs for physician fee-for-service payments, emergency room contract payments and funding for out-of-province services.

PharmaCare

The surplus in PharmaCare is primarily due to lower than anticipated expenditures under the Fair PharmaCare Program introduced in May 2003. The savings were partially offset by an increase in expenditures under PharmaCare Plan C — the plan providing drug coverage for those on income assistance.

Debt Service Costs

The surplus in debt servicing is the result of lower than expected capital spending, the timing of borrowings and lower than expected interest rates.

Emergency Health Services

This area was over its planned budget due to wage increases, enhanced training for paramedics, the addition of new paramedic positions to support service delivery plans formulated by health authorities, and increased service volumes.

Health Benefits Operations

This area was over its planned budget due to enhancements to improve service levels, and an increased operational workload due to the implementation of Fair PharmaCare.

Program Management and Corporate Services

This variance is primarily due to unanticipated costs related to leave liability and other employee benefits.

2003 First Ministers' Accord on Health Care Renewal

In 2003, the Provinces, Territories and Federal Government reached a First Ministers' Accord on Health Care Renewal. Additional funding under the Accord is intended to provide investments in primary care, home care and catastrophic drug coverage, and also includes funding for specialized equipment and training to improve access to diagnostic services. The ministry and its health authority partners are using this funding to support our strategic priorities in these areas.

	Budget ($ – millions)	Expenditures ($ – millions)	Notes
Canada Health and Social Transfer			
• Pharmacare	129.4	129.4	Funding provided to meet growing public demand for needed drug therapy.
Health Reform Fund			
• Regional Health Sector Funding	130.0	130.0	Funding provided to health authorities.
Diagnostic/Medical Equipment Fund			
• Regional Health Sector Funding	60.0	21.7	Funding for medical equipment (for details see page 83). *
Total	**319.4**	**281.1**	

* The budget was under spent due to the length of time required to order and receive specialized medical equipment. The unspent budget will be applied toward future year purchases to a total of $200.1 million.

Capital Expenditures and Financing Transactions

Capital Planning

To support the province's long-term goal of a more sustainable and effective health care system, capital planning in the health sector is undergoing a number of major strategic shifts. In 2003/04, the ministry moved to a more outcome-based approach, and focused on promoting best practices in capital planning and management, giving health authorities an increased degree of autonomy with regard to planning and implementing projects. This allocation of authority and accountability reflects the ministry's stewardship role, and permits health authorities to respond more effectively to regional needs.

New provincial policy guidelines were implemented which support health authorities in developing a more flexible approach to meeting infrastructure needs through a variety of funding sources (public, non-profit, private) and methods of procurement.

In 2003/04, health authorities submitted multi-year Capital Asset Management Plans to the ministry for the first time. The development of a capital asset management plan is a cornerstone of good planning and management for provincial public sector agencies.

Health Sector Inventory and Assessment

In 2003/04, the ministry commenced a province-wide inventory and assessment of health authority-owned facilities, land, major equipment and leased premises. This is the first time that such a comprehensive inventory of public and not-for-profit health system assets has been conducted in British Columbia, and it is anticipated the results will significantly enhance decision-making for health authorities. A comprehensive database will allow health authorities to compare assets in a more meaningful way, prioritize projects, and assess the nature and cost of capital investment required to meet future service delivery needs.

Three-Year Capital Spending Plan

The ministry's three-year capital spending plan encompasses maintenance, renovation, replacement and expansion of health infrastructure that is consistent with regional priorities. For 2003/04 it included:

Restructuring Allocation

A $100 million restructuring allocation for health authorities was established in the 2002/03 fiscal year to convert existing health facilities to uses consistent with regional and provincial priorities, achieve building and operational efficiencies, and implement best practices. This work is to be completed by 2005/06. At March 31, 2004, $58.3 million has been approved from this allocation, including:

- Interior Health Authority — $7.8 million shared food services project.

- Fraser Health Authority — Burnaby Hospital's $2.6 million renovation to consolidate mental health services.
- Provincial Health Services Authority — B.C. Children's and Women's Health Centre's $1.6 million Labour Delivery Suite/Surgical Day Care Unit renovation.
- Northern Health Authority — Chetwynd General Hospital's $1 million renovation to incorporate community health services.
- Vancouver Coastal Health Authority — Vancouver General Hospital's $2.3 million Emergency Room renovation to accommodate expected increased patient volumes.
- Vancouver Island Health Authority — Victoria General Hospital's $2.1 million renovation to develop an inpatient rehabilitation unit.

Note: In some cases, costs are shared with funding partners such as regional hospital districts or foundations.

Mental Health Plan — Riverview Redevelopment

A $138 million capital allocation, commencing in 2002/03, is targeted for development of mental health beds for Riverview patients to be relocated to suitable facilities in their respective health authorities. At March 31, 2004, $28.4 million has been approved from this allocation.

The Provincial Health Services Authority is leading the redevelopment process with its health authority partners. Projects include:

- New seven bed mental health home — Vernon, $407,000. Completed in February 2004.
- Cottonwoods 11 bed Tertiary Rehab Facility — Kelowna, $1.7 million. Approved in March 2004. Expected completion in June 2005.
- Seven Sisters 20 bed Adult Residential Mental Health Facility — Terrace, $2.5 million. Approved in August 2003. Expected completion in October 2004.
- Bulkley Valley Lodge Renovation for 14 Psychogeriatric beds — Smithers, $1.7 million. Approved in November 2003. Expected completion in October 2004.
- North Peace Care Centre eight bed Psychogeriatric Renovation — Fort St. John, $1.5 million. Approved in January 2004. Expected completion in October 2004.

First Ministers' Accord on Health Care Renewal — Diagnostic and Medical Equipment Fund

The 2003 First Ministers' Accord on Health Care Renewal established a $1.5 billion national diagnostic and medical equipment fund. Of that total, $200.1 million was allocated to BC for the three-year period ending in 2005/06. The ministry had originally intended to spend $60 million in 2003/04; however, due to the length of time required to order and receive specialized medical equipment, $21.7 million has been spent to March 31, 2004. The unspent portion will be applied to future years. The following table outlines spending to date by category.

Diagnostic/Medical Equipment Fund	
Diagnostic — Imaging (e.g., CT Scanners)	$6.1 million
Diagnostic — Other and Therapeutic (e.g., laboratory equipment)	$2.8 million
Medical and Surgical (e.g., anaesthetic machines)	$6.5 million
Patient Comfort and Safety (e.g., patient lifts, beds, mobility equipment, bathing equipment)	$6.3 million
Total	**$21.7 million**

Specific examples include:

- Lion's Gate and Richmond Hospitals — Replacement of two CT Scanners ($1.4 million each).
- Equipment related to radiographic fluoroscopy in Squamish and Chilliwack ($1.2 million).
- Royal Columbian Hospital — Cardiac Catheterization Lab Replacement ($2.4 million).
- Royal Columbian Hospital — three Gamma Cameras ($1.1 million).
- Royal Jubilee Hospital in Victoria — Angiographic System ($2 million).
- Screening Mammography Program of BC (White Rock) Mammography Unit ($83,000).
- Radiotrophic Tomographic Units for Hazelton, Chetwynd, Burns Lake, and Vanderhoof ($300,000 - $375,000).
- Anaesthetic Machines for Smithers and Vanderhoof ($150,000 each).
- Across the Interior Health Region — patient beds and lifting devices to improve patient and staff comfort and safety ($3.1 million).

Major Capital Projects

Under the *Budget Transparency and Accountability Act*, a summary of the business case for major capital projects must be made public. A major project is defined as any capital commitment or anticipated commitment that exceeds $50 million. In 2003/04, commitments were made to the following major capital projects:

Vancouver General Hospital Redevelopment (VGH) — Vancouver Coastal Health Authority

Objective: Hospital redevelopment is to consolidate patient services and clinical expertise, research and teaching resources to assist in meeting patient care needs over the next 20 years or more.

Cost: Total capital cost is $156 million.

Benefits: Anticipated benefits are new patient areas and consolidation of hospital services within the Centennial Pavilion and the Jim Pattison Pavilion. Relocation of services to the new buildings is a vital part of creating a modern and efficient hospital environment for enhanced patient care and accessibility.

Risks: The project could potentially be affected by factors such as delays, changes in economic and market conditions (including potential for labour and material cost escalation and shortages), and scope, design, technology and/or building code changes.

The project is due for completion in 2007.

Prince George Regional Hospital Redevelopment (PGRH) — Northern Health Authority

Objective: To provide high quality health care services that meet patients' needs.

Cost: Capital cost of the project is $50 million.

Benefits: The modernized facility will provide improved diagnosis and treatment for northern residents. As a major regional referral and training centre, it will also support the recruitment of health professionals to the community.

Risks: With completion scheduled for 2004, the risk profile at this stage in the project is small.

Public-Private Partnerships

The ministry and health authorities are committed to ensuring maximum value for health care dollars and are exploring new approaches for capital projects. In accordance with that approach, the ministry and health authorities have pursued public-private partnerships (P3s) to leverage private sector innovation and capital.

Abbotsford Hospital and Cancer Centre (AHCC) — Fraser Health Authority and Provincial Health Services Authority

Objective: AHCC is a state-of-the-art regional referral health campus to replace the aging Matsqui-Sumas-Abbotsford (MSA) Hospital.

Cost: The capital cost of the project is estimated to be approximately $300 million.

Benefits: The new hospital will provide enhanced programs and services to meet the needs of Fraser Valley residents for the next 30 years, and will also help to recruit and retain health professionals. AHCC includes integration of a new cancer treatment centre that will be part of the provincial network operated by the BC Cancer Agency.

Risks: This is the province's first P3 project for a major acute care facility. To mitigate the first-time-through risks, the AHCC team is building upon the experience, documentation and advice of other jurisdictions that have completed similar projects.

Risks will be allocated between the parties as part of the P3 contractual agreement. For example, it is expected that the private sector partner will manage the design and construction risk.

As of March 31, 2004, the project was in the procurement phase and completion is anticipated for 2008.

Academic Ambulatory Care Centre (AACC) — Vancouver Coastal Health Authority

Objective: The objective of the AACC project is to replace outdated facilities and coordinate outpatient care services at the VCHA Vancouver General Hospital, including specialty clinics, medical education, physician practice offices, research and related commercial/retail activities.

Cost: The capital cost of the facility is estimated at $91 million.

Benefits: By centralizing medical disciplines, this modern facility will enhance patient access, scheduling and care by allowing the coordination of specialist visits, clinic visits and diagnostic testing in one location. In addition, medical students will benefit from increased interaction between academics, researchers and practicing clinicians.

Risks: Risks will be allocated between the parties as part of the P3 contractual agreement. For example, it is expected that the private sector partner will manage the design and construction risk.

As of March 31, 2004, AACC was in the procurement phase and completion is anticipated for 2006.

Appendix 1: Acts Under the Administration of the Minister of Health Services

Access to Abortion Services Act

Anatomy Act

BC Benefits (Income Assistance) (Healthy Kids Orthodontia Program) Act

Chiropractors Act

Community Care Facility Act

Continuing Care Act

Dentists Act

Drinking Water Protection Act

Emergency Contraceptive Access Act

Forensic Psychiatry Act

Health Act

Health and Social Services Delivery Improvement Act, except Part 3

Hearing Aid Act

Health Authorities Act

Health Care (Consent) and Care Facility (Admission) Act

Health Emergency Act

Health Professions Act

Health Sector Partnerships Agreement Act

Health Special Account Act

Hospital Act

Hospital District Act

Hospital Insurance Act

Human Tissue Gift Act

Marriage Act

Meat Inspection Act

Medical Practitioners Act

Medicare Protection Act, except ss. 5 (1)(b), 7(5), 8(4), 8.1, 8.2 and 32

Mental Health Act

Milk Industry Act, s. 12, except in respect of tank milk receiver licences
Ministry of Health Act
Name Act
Nurses (Registered) Act
Optometrists Act
Pharmacists, Pharmacy Operations and Drug Scheduling Act
Podiatrists Act
Public Toilet Act
Tobacco Damages and Health Care Costs Recovery Act
Tobacco Sales Act
Venereal Disease Act
Vital Statistics Act
Wills Act — Part 2

Appendix 2: Professions Regulated by the Minister of Health Services

Acupuncturists
Chiropractors
Dental Hygienists
Dental Technicians
Dentists
Denturists
Dietitians
Emergency Medical Assistants
Hearing Aid Dealers (including audiologists in private practice)
Licensed Practical Nurses
Massage Therapists
Medical Practitioners
Midwives
Naturopaths
Occupational Therapists
Opticians
Optometrists
Pharmacists
Physical Therapists
Podiatrists
Psychologists
Registered Nurses
Registered Psychiatric Nurses
Traditional Chinese Medicine Practitioners

Appendix 3: *New Era* Commitments

New Era Commitment	Status	Action
Expand training and post-secondary programs to graduate more Care Aides, Licenced Practical Nurses and Registered Nurses.	Ongoing	Since 2001, the government has added approximately 2,000 new education spaces for nurses in local colleges, institutes, university colleges and universities throughout the province. More than 700 nurses have been funded to take refresher, qualifying or English as a second language courses. This allows non-practicing Canadian graduates or internationally educated non-practicing BC residents to be eligible to return to nursing.
Develop a Rural and Remote Training Program that provides forgivable loans to BC students attending accredited nursing and medical schools who agree to practice in a rural or remote community in BC.	Done	The loan forgiveness program was established in August 2001. Loans are forgiven at a rate of 33 per cent per year for each year of service in rural or remote communities.
Increase the number of medical school graduates over the next five years.	Underway	The medical school at UBC is being expanded and will include new satellite campuses at UNBC and UVic. Medical-school spaces will almost double, to 224 from 128, by 2005.
Ensure that BC health care is universal, accessible, portable, comprehensive and publicly administered, consistent with the five principles of the Canada *Health Act*.	Ongoing	Health authorities have established three-year Health Service Plans, updated annually, to reform and renew patient services for each region, along with new province-wide standards for care.
Establish provincial health standards that ensure all citizens in every part of the province are entitled to equitable, reliable, high quality health services.	Done	Province-wide access standards have been established for emergency, acute care and specialty services. The government was the first administration in this province to implement a system of performance agreements with health authorities, which holds these agencies accountable for the services they deliver and how they are delivered.
Develop performance measures that are annually audited and publicly reported for each health standard, to ensure provincial and regional health authorities are accountable for fulfilling their duties to provide the prescribed levels of patient care.	Done	Accountability contracts and measures have been established, along with three-year health service plans for each authority. The government has also provided health authorities with three-year funding commitments, updated annually, to enable them to plan and act with certainty. Government is continuing to redesign the health care system so that funding for health authorities is spent efficiently and focused on public health and patient care.

New Era Commitment	Status	Action
Develop a 10-year human resource plan, that properly provides for the training, recruitment and retention of physicians, nurses, specialists and other health care providers in every area of the province, and that addresses critical skills shortages and staffing levels in under-serviced areas.	Underway	As a first step, programs have been launched to expand the supply of nurses and doctors. Since September 2001, government has committed $59 million to the nursing strategy, which includes the creation of approximately 2,000 new education spaces for nurses in local colleges, institutes, university colleges and universities throughout the province, and increased the number of nurses licensed to practice in BC by more than 600 since 2001. A total of 45 new spaces for nurse practitioners will be added. Since 2001, government has funded more than 700 nurses to take refresher, qualifying, or English as a second language courses. This allows non-practicing Canadian graduates or internationally educated non-practicing BC residents to be eligible to return to nursing. A $134 million expansion of the University of British Columbia's medical school facilities almost doubles the number of spaces, and provides training through satellite centres in Victoria and Prince George — a first in BC. This will provide opportunities for medical students to train and establish practices in their home regions, and help alleviate shortages of doctors throughout the province. Currently, we graduate 128 doctors per year. We will increase the number of medical school spaces by 2005, and will graduate 224 new doctors each year by 2009. Since July 2003, the Ministry of Health Services has approved funding for 32 new postgraduate entry-level positions — the beginning of the stepped expansion to the postgraduate (residency) medical education program. Over the next decade residencies will expand to keep pace with the MD undergraduate program expansion. In 2004/05, the Ministry of Health Services committed $54.4 million in operating funding for the Postgraduate Medical Education Program, up from $47.6 million in 2003/04. The ministry also committed $27.6 million in capital funding for increased academic space in teaching hospitals and affiliated regional centres.

***New Era* Commitment**	**Status**	**Action**
Develop a Hospital Facilities Plan that identifies each health region's key capital requirements and funding priorities.	Ongoing	The Ministry of Health Services is working with health authorities to develop and implement multi-year capital plans that address immediate and long-term needs in the hospital sector through service redesign and modernizing facilities.
Develop an Intermediate and Long-Term Care Facilities Plan, that addresses the needs of our aging population and frees up existing acute care beds.	Underway	Health authorities are modernizing home and community care to provide more care options for seniors. The facilities plan will ensure seniors have a range of housing and care services, depending on their needs and abilities.
Develop a Medical Machinery and Equipment Plan that ensures existing medical diagnostic and care equipment is adequately staffed, fully utilized and properly maintained, and that provides for future investments in new equipment and technologies.	Ongoing	The Ministry of Health Services is working with health authorities to develop and implement multi-year capital plans that promote a more strategic approach to maintaining and updating health care system equipment. To assist health authorities in meeting their identified needs, $200.1 million in federal funding from the 2003 First Ministers' Accord on Health Care Renewal is being allocated over three years for investment in diagnostic and medical equipment and training of specialized staff. The ministry has established a committee to advise on new technologies and priorities for improving health care delivery.
Develop a comprehensive Technology Plan to assist health care professionals in delivering faster, more effective treatment to patients through new information technology and telemedicine.	Underway	The province is funding $15 million in tele-health programs across BC, including a new filmless medical imaging system launched in April 2003. Tele-health programs provide emergency and trauma, pediatric, maternity and mental health services for 30 communities. BC's CIO Council has developed a strategic plan on the main goals and priorities to support the health system and health service delivery, as well as a tactical plan. The ministry and its partners are also developing a strategic plan on the Electronic Health Record, as part of a comprehensive technology plan to assist health professionals and improve patient care across the province.

New Era Commitment	Status	Action
Establish a Rural and Remote Health Initiative to ensure all families get the care they need, where they live, when they need it.	Underway	The province has funded $58.5 million in incentives and benefits to attract doctors to rural practices. It established a rural specialist locum program to ensure continuous coverage during the recruitment process and introduced the first Interprofessional Rural Program in Canada to place students from various health professions in rural areas for training.
Introduce a Rural and Remote Training Support program that provides financial and travel assistance to health care providers who want to update or upgrade their skills and training.	Underway	The government's Nursing Strategy provided more than 6,000 nurses with continuing and specialty training in much-needed nursing specialties, and the BC Ambulance Service has received $30 million for new measures aimed at strengthening ambulance service across the province.
Maintain this year's overall $9.3 billion budget for health.	Done	In addition to maintaining funding, spending has increased.
Increase future health care funding as economic growth increases government revenues.	Done	In fact, health funding now accounts for 43 per cent of all government spending. Spending on health in British Columbia has increased $2 billion since 2001/02.
Work with front-line health care professionals to act on their ideas for maximizing the value to patients of every health dollar spent.	Ongoing	The Dialogue on Health in October 2001 brought together 140 professionals, administrators and other experts. The Legislature's Select Standing Committee on Health held hearings in 10 communities and received 700 submissions for its December 2001 report on health-care renewal.
Provide health regions and hospitals with 3-year rolling funding commitments (updated annually), to enable them to plan and act with certainty.	Done	Three-year rolling funding commitments, updated annually, were first provided with Budget 2002.
Fully fund and implement the $125 million mental health initiative.	Done	The government is implementing a $263 million mental health commitment, including the $125 million mental health plan and $138 million for facilities.
Fund health regions at a level necessary to meet the needs of the people who live there, regardless of where a service is provided.	Done	Funding for BC's six health authorities now exceeds $6.1 billion.

***New Era* Commitment**	**Status**	**Action**
Replace obsolete hospital equipment and ambulance equipment and ensure all equipment is fully utilized and properly maintained.	Ongoing	Health authorities are working to replace obsolete hospital equipment. This includes the development of capital plans and identifying priorities for allocating $200.1 million over three years in federal funding from the 2003 First Ministers' Accord on Health Care Renewal. In 2003/04, the British Columbia Ambulance Service (BCAS) continued to upgrade its equipment, purchasing $1 million of specialized telecommunications equipment, and $1 million on medical equipment, including stretchers, IV pumps, vital signs monitors, and pulmonetic systems. In 2002/03, defibrillators were installed on all 450 BC ambulances.
Fulfill BC's obligations under the *Canada Health Act* to properly fund and provide access to all medically necessary services.	Ongoing	Annual spending on health in British Columbia has increased $2 billion since 2001/02 and will increase an additional $1 billion by 2006/07.
Focus funding on patient care, by reducing waste in the system and eliminating administrative duplication and costs from provincial government mismanagement.	Done	The number of health authorities has been reduced from 52 to six, to achieve greater efficiency. Health authorities are on target to achieve administrative savings of seven per cent — a total reduction of $97.1 million by end of 2004/05. Since 2001/02, ministry administrative FTEs have been reduced by 45 per cent, so financial resources can be redirected to front line services.
Provide assistance and opportunities to help nurses develop the specialized skills needed in intensive care units, emergency rooms and operating rooms.	Ongoing	The government's $59 million nursing strategy has helped BC gain 614 nurses since 2001. It has also provided more than 6,000 nurses with continuing and specialty training in critical and emergency care, and helped nurses on workers' compensation and long-term disability to return to work.
Increase training spaces and recruitment of foreign-trained nurses and physicians.	Ongoing	Since 2001, we have funded more than 700 nurses to take refresher, qualifying or English as a second language courses. This allows non-practicing Canadian graduates or internationally educated non-practicing BC residents to be eligible to return to nursing. Also, government is working with Health Canada to expedite international medical graduate assessment and with other partners to improve the provision of placements.

New Era Commitment	Status	Action
Launch a massive recruitment drive to bring non-practicing RNs and LPNs back into our health care system.	Underway	The government's nursing strategy helped BC gain 614 nurses since 2001. Since 2001, we have funded more than 700 nurses to take refresher, qualifying or English as a second language courses. This allows non-practicing Canadian graduates or internationally educated non-practicing BC residents to be eligible to return to nursing.
Increase locum support to relieve pressure and reduce workloads, to enhance health care professionals' quality of life.	Done	Funding for the general practitioner rural locum program increased by 50 per cent, to $1.85 million in 2003/04 from $1.25 million in 2001/02.
Increase the number of residency positions in BC's hospitals in the next five years.	Ongoing	Government has introduced a $134 million medical school expansion. It will almost double the number of BC medical school spaces, to 224 from 128, by 2005, and will open up new residency positions in BC hospitals outside the Lower Mainland. Since July 2003, the Ministry of Health Services has approved funding for 32 new postgraduate entry-level positions — the beginning of the stepped expansion to the postgraduate (residency) medical education program. Over the next decade, residencies will expand to keep pace with the MD undergraduate program expansion. In 2004/05, the Ministry of Health Services committed $54.4 million in operating funding for the Postgraduate Medical Education Program, up from $47.6 million in 2003/04. The ministry also committed $27.6 million in capital funding for increased academic space in teaching hospitals and affiliated regional centres.
Give ambulance attendants better access to training and better life-support and communications equipment needed to capitalize on those skills.	Done	$30 million was allocated in May 2002 for ambulance services, including funding to upgrade 1,300 rural paramedics to Paramedic 1 level. Defibrillators are now in use on all 450 BC ambulances — $780,000 was spent in 2001-02, plus $350,000 last year.

New Era Commitment	Status	Action
Ensure that appointees to regional health boards are representative of their communities' needs and accountable for their performance in meeting provincial health standards.	Done	Six new health authorities have been established, new boards appointed and new Performance Agreements and measures established. Through BC's Board Resourcing and Development Office, board member appointments are carefully considered to ensure necessary skills for the effective management and delivery of health care. This is the first administration in this province to implement a system of performance agreements with health authorities, which holds these bodies accountable for the services they deliver and how they are delivered.
Pressure the federal government to restore all of the health care funding withdrawn through budget cuts.	Ongoing	As a result of the First Ministers' Accord on Health Care Renewal, in February 2003, the federal government agreed to provide $20 billion in new funding for patient care in Canada over five years, with an extra $2 billion if there was a federal surplus in 2003/04. BC's share of the federal funding in 2004/05, including the share of the $2 billion supplement, is $529 million ($328 million plus $131 million supplement plus $70 million for equipment). There will also be an additional $17 million from the Public Health and Immunization Trust. This money will be directly invested to improve further public health and patient care.
Work with non-profit societies to build and operate an additional 5,000 new intermediate and long-term care beds by 2006.	Underway	The province is developing new residential care beds, supportive housing and assisted living spaces to ensure seniors and people with disabilities have a range of housing and care options. As a first step, Independent Living BC was established in May 2002 to develop 3,500 independent living units with support services across the province.
Provide expanded home care and palliative care services to assist chronically and terminally ill patients with supportive home environments, as an option to institutional care.	Ongoing	The province is finalizing an end-of-life care strategy as the first step toward developing a health system that provides compassionate, competent and respectful care. In addition, an expanded palliative care drug benefits program enables British Columbians to receive care in the comfort of their home. The number of hospice beds has nearly doubled since 2001, and more beds are in planning.

***New Era* Commitment**	**Status**	**Action**
Build a unified, universal, and cost-effective health services information network that will improve care and reduce long-term costs.	Ongoing	The province is working with the health sector and Canada Health Infoway to create a provincial Electronic Health Record Framework that will provide integrated, higher-quality health care with greater efficiencies. The new *Personal Information Protection Act*, passed in October 2003, ensures that adequate privacy and security provisions are in place.
Develop a rural travel assistance program, to reduce rural patients' transportation and lodging costs to receive treatment that is not locally available.	Underway	A new $5-million Rural Travel Assistance Program is being developed and will assist patients who have to travel outside of their region to receive a higher level of care.
Ensure that patients living at home in palliative or long-term care are entitled to the same pharmaceutical benefits as they would have if they were in a hospital.	Underway	The province is reviewing the palliative care benefits program to ensure it provides terminally ill patients in their homes and residential care facilities with medication, medical supplies and equipment at no charge.
Give all citizens better access to their medical records and treatment histories, and enhanced information privacy rights.	Ongoing	The province is working with the health sector and Canada Health Infoway to create a provincial Electronic Health Record Framework that will provide integrated, higher-quality health care with greater efficiencies. The new *Personal Information Protection Act*, passed in October 2003, ensures that adequate privacy and security provisions are in place.
Support community services volunteers and repeal the NDP legislation that allowed government to expropriate community health facilities without compensation.	Done	The section of the *Health Authorities Act* allowing assets to be seized without compensation was repealed in August 2001.
Protect current funding and existing levels of access to abortion services throughout the province, as a matter of confidence in government.	Done	Funding and access to abortion services has been maintained.

New Era Commitment	Status	Action
Intensify efforts to promote wellness and preventative care through better education, dietary habits and physical activity.	Ongoing	Under its Picture of Health vision, the province has launched a wellness and prevention initiative that includes Action Schools! BC, introduced to address elementary students' physical activity levels and lifestyles. The province also has formed the Provincial Chronic Disease Prevention Alliance to strengthen chronic disease support and prevention. Through the NurseLine and other components of the BC HealthGuide, British Columbians have 24/7 access to health-care information.
Double the Physical Fitness and Amateur Sports Fund to $44 million, to promote physical fitness and participation in amateur sport.	Done	Funding has been increased to double the fund over four years.
Enhance preventative drug and alcohol efforts, such as addiction counselling for new mothers and the reduction of fetal alcohol syndrome.	Ongoing	The Premier released Canada's most comprehensive fetal alcohol spectrum disorder (FASD) prevention strategy in September 2003.
Work to minimize interjurisdictional overlaps that are adding confusion and costs to health care delivery.	Done	The number of health authorities has been reduced to six from 52, to provide greater efficiency and co-ordination within regions.
Work with doctors, pharmacists and others to find a cost-effective alternative to reference-based pricing.	Done	The consultation panel review of the Reference Drug Program (RDP) was completed in 2002, and a report with recommendations was issued. Further, the government asked the ministry to conduct a broad review of PharmaCare to create a drug program that is sustainable while continuing to put patients first in providing access to important classes of drugs. It also included improved information sharing among physicians, pharmacists and the public to support decision making, and consultation with health care providers and other stakeholders. This review began in September 2003, and the first phase has been completed.
Provide better home support and home care services.	Ongoing	Health authorities are focusing their resources on direct patient care needs to enable people with high care needs to live in their homes as long as possible.